

Clinicians May Not Administer Life-Sustaining Treatment without Consent: Civil, Criminal, and Disciplinary Sanctions

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I. Introduction

New York physician Mahmood Yoonessi, a specialist in gynecologic oncology,¹ performed an “extensive surgical procedure” on a 67-year-old patient with advanced ovarian cancer.² Unfortunately, the patient developed problems post-operatively necessitating blood transfusions, and lost decision-making capacity.³ The patient’s family was then empowered to make treatment decisions on the patient’s behalf.⁴ They soon determined that “enough was enough.”⁵ So, they authorized the entry of a Do Not Attempt Resuscitation order (“DNR”) and directed that the patient receive no further transfusions.⁶

But Dr. Yoonessi rejected these instructions, because he “wanted to further aggressively treat the patient.”⁷ He said, “I don’t care what the family wants,” and ordered blood anyway.⁸ Furthermore, Dr. Yoonessi told the family that “they were being like Jack Kevorkian, that if this was his mother he wouldn’t allow this to happen, and that they were playing God by not allowing their mother to have further treatment.”⁹ Dr. Yoonessi, in short, deliberately disregarded the wishes of the patient and her authorized surrogates.

This sort of scenario plays out far too often across the United States. It has been nearly 100 years since Judge Cardozo’s famous and oft-quoted statement of individual self-determination: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a [physician] who performs [an intervention] without his patient’s consent . . . is liable in damages.”¹⁰ But over the past century, this principle of patient autonomy has, unfortunately, been honored more in word than in deed.

On the one hand, U.S. courts and legislatures have developed a substantial body

¹ *In re Yoonessi*, N.Y. Bd. Prof. Med. Conduct, N.Y. Dep’t Health, No. BPMC 02-188, 2002 WL 33840948 (N.Y.B.P.M.C. June 5, 2002).

² *Id.* at *15.

³ *Id.* at *16.

⁴ *Id.*

⁵ *Id.*

⁶ *Yoonessi*, 2002 WL 33840948, at *16.

⁷ *Id.*

⁸ *Id.* at *18.

⁹ *Id.* at *16.

¹⁰ *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *abrogated by Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957).

of informed consent and other patients' rights jurisprudence. On the other hand, clinical practice has not evolved nearly as far, nor as quickly, as the law. "However clean, neat, and legal the right to refuse life-sustaining treatment may seem on paper, it is not always so clean, neat, and practical inside a hospital room."¹¹ "There is a significant difference between the black letter law of patients' rights and the actual practice within the hospital setting."¹²

A major explanation for the persistent gap between medical-legal principle and the reality of medical practice is ignorance and misunderstanding of the law. In the clinical setting "myths about the law often overshadow reality."¹³ "The most efficacious social facts in the actual hospital situation are [provider] perceptions themselves, not the objective risks."¹⁴

Often, clinicians' perceptions are that legal risks are far *greater* than they actually are. This is the cause of much defensive medicine.¹⁵ This is particularly true with respect to end-of-life care.¹⁶ In contrast to this generalization, with respect to administering life-sustaining treatment without consent, the perception is that the legal risks are *lower* than they actually are.¹⁷

¹¹ Kellen F. Rodriguez, *Suing Health Care Providers for Saving Lives*, 20 J. LEG. MED. 1, 4 (1999); see also Phillip G. Peters, *The Illusion of Autonomy at the End of Life: Unconsented Life Support and the Wrongful Life Analogy*, 45 UCLA L. REV. 673, 674 (1998). "[A]s a matter of legal doctrine, a patient's right to refuse life-sustaining care is virtually absolute. In hospital wards, however, that right is often illusory." *Id.*; John Donohue, *Wrongful Living: Recovery for a Physician's Infringement on an Individual's Right to Die*, 14 J. CONTEMP. HEALTH L. & POL'Y 391, 419 (1998). "Barring a dramatic shift in judicial sentiment, the right to refuse lifesaving medical treatment . . . will remain a right in name only without any significant remedy at law." *Id.*

¹² M. Rose Gasner, *Financial Penalties for Failing to Honor Patient Wishes to Refuse Treatment*, 11 ST. LOUIS U. PUB. L. REV. 499, 519 (1992).

¹³ Bethany Spielman, *Bargaining about Futility*, 23 J. L. MED. & ETHICS 136, 137 (1995).

¹⁴ Stephen Toulmin, *Institutions and their Moral Constraints*, in INTEGRITY IN HEALTH CARE INSTITUTIONS: HUMANE ENVIRONMENTS FOR TEACHING, INQUIRY, AND HEALING 21, 26 (Ruth E. Bulger & Stanley J. Reiser eds., 1990); see also Alan Meisel, *The Role of Litigation in End of Life Care: A Reappraisal*, HASTINGS CENTER REP. S47, S48 (Nov.-Dec. 2005); Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 L. & CONTEMP. PROBLEMS 119, 119 (1991). "[T]o the extent that a crisis is in fact widely perceived, it has the quality of a self-fulfilling prophesy" *Id.*

¹⁵ See Thaddeus M. Pope, *Physicians and Safe Harbor Legal Immunity*, 21 ANNALS HEALTH L. 121, 121 (2012).

¹⁶ See Thaddeus M. Pope & Ellen A. Waldman, *Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure*, 23 OHIO ST. J. ON DISP. RESOL. 143, 171-73 (2007).

¹⁷ See *infra* Sections IV-V.

In this Article, I argue that this perception is inaccurate. First, it is based on an outdated data set, primarily damages cases from the 1990s. More recent plaintiffs have been comparatively more successful in establishing civil liability. Second, the published assessments focus on a highly limited data set. Even if the reviewed cases were not outdated, a focus limited to civil liability would still be too narrow. Legal sanctions have also included licensure discipline and other administrative sanctions. In short, the legal risks of providing unwanted life-sustaining treatment are not as rare, meager, and inconsequential as often depicted. In fact, sanctions for administering unwanted treatment are significant and growing.

In Section II, I quickly summarize the now well-established legal bases for the right to refuse life-sustaining treatment. In Section III, I demonstrate that clinicians regularly breach their duty to respect patients' right to refuse. In addition to reviewing the literature, I summarize key statistical measures establishing the size and scope of the problem. Fortunately the reports are not all bad. The prevalence of unwanted life-sustaining treatment may be shrinking with the increasing implementation of Physician Orders for Life Sustaining Treatment ("POLST"). Still, the problem remains significant.

In Section III, I identify twelve leading factors that cause clinicians to administer unwanted life-sustaining treatment: (a) inadequate advance care planning, (b) clinician misinterpretation of and confusion on advance directives, (c) uncertain validity of advance directives, (d) uncertain application of advance directives, (e) demanding and conflicting surrogates, (f) uncertain status of the surrogate decision maker, (g) uncertain patient decision making capacity; (h) inadequate informed consent, (i) negligent maintenance of medical records, (j) vitalistic philosophy of medicine, (k) conscience-based objections, and (l) financial incentives.

In Section IV, I establish that clinicians believe administering unwanted life-sustaining treatment entails little legal risk. This perception is based on three main factors. First, clinicians are often able to obtain injunctions and guardianships authorizing treatment. Second, the salience of unsuccessful cases for damages makes it appear that administering unwanted treatment entails little legal risk. Third, this perception is bolstered by the visibility of five legal obstacles to liability: (a) rejection of the "wrongful living" cause of action, (b) rejection of private claims under the Patient Self-Determination Act ("PSDA"), (c) the emergency exception to the consent requirement, (d) safe harbor immunity under healthcare decisions acts, and (e) conscience clauses.

Finally, in Section V, I demonstrate that this "no risk," "low risk" perception is

wrong. I show how health care providers have been increasingly subject to sanctions for administering unwanted life-sustaining treatment. I review nine theories of civil liability: (a) battery, (b) informed consent, (c) negligence, (d) intentional infliction of emotional distress, (e) negligent infliction of emotional distress, (f) breach of contract, (g) health care decisions statutes, (h) POLST statutes, (i) Section 1983, and (j) the False Claims Act. I also review administrative sanctions and criminal liability. Furthermore, not only have providers already been sanctioned, but with recent increased patient protections, they are also likely to be increasingly sanctioned.

The right to refuse life-sustaining treatment has been established for decades. But, as with many principles in bioethics, like the related doctrine of informed consent,¹⁸ there remains a wide chasm between legal and ethical principles, on the one hand, and the reality of clinical practice, on the other. In contrast to other commentators, I have aimed to establish that the prospect for enforcement and protection of patient rights is not as dismal as commentators often depict. In fact, both private litigants and government regulators have been imposing sanctions that are increasingly severe and frequent.

II. Right to Refuse Life-Sustaining Treatment

Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of lifesaving [treatment].

— Justice Alfred G. Shroeder, *Natanson v. Kline*¹⁹

For some individuals, the possibility of extended life is meaningful and beneficial. For others, the artificial prolongation of life provides nothing beneficial, serving only to extend suffering and prolong the dying process.²⁰ To accommodate these varying attitudes, the rise of modern life-sustaining medical technologies was accompanied by the rise of patient autonomy. During the 1970s and 1980s, appellate courts across the country decided numerous cases in which patients and patients'

¹⁸ See Thaddeus M. Pope, *Legal Briefing: Informed Consent*, 21 J. CLINICAL ETHICS 72, 72 (2010).

¹⁹ 350 P.2d 1093, 1104 (Kan. 1960); see also *Cruzan v. Dir., Mo. Dep't Health*, 497 U.S. 261, 269 (1990). "[N]o right is held more sacred . . . than the right of every individual to the possession and control of his own person . . ." *Id.*

²⁰ See Thaddeus M. Pope & Lindsey A. Anderson, *Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life*, 17 WIDENER L. REV. 363, 368-70 (2011) (discussing how individuals with serious physical and cognitive impairments may find their lives no longer worth living).

families wanted to withdraw or withhold life-sustaining medical treatment, but their health care providers were reluctant to cede to such requests. These courts almost uniformly ruled for the patients, finding a right to refuse that was not outweighed by state interests. The courts variously grounded this right in the common law,²¹ in state constitutions,²² in the United States Constitution,²³ and in other legal sources.²⁴

These cases firmly established the right of patients to refuse life-sustaining medical treatment.²⁵ These cases also established the rights of surrogates to exercise this right for patients who were incompetent and unable to exercise it for themselves.²⁶ Today, all states have laws enabling patients and surrogates to refuse medical care.²⁷ Patients and surrogates decide whether life-sustaining medical treatment is of benefit given their own values and given their own particular circumstances. Health care providers must generally comply with decisions to refuse life-sustaining medical

²¹ See, e.g., *Barber v. Superior Ct.*, 195 Cal. Rptr. 3d 484, 489 (Cal. App. 1983); *In re Estate of Longeway*, 549 N.E.2d 292, 297 (Ill. 1989); *In re Gardner*, 534 A.2d 947, 951 (Me. 1987); *In re Peter*, 529 A.2d 419, 422-23 (N.J. 1987).

²² See, e.g., *Mack v. Mack*, 618 A.2d 744, 755 (Md. 1993); *Rasmussen v. Fleming*, 741 P.2d 674, 682 (Ariz. 1987); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983).

²³ See, e.g., *Crusian*, 497 U.S. at 280; *In re Severns*, 425 A.2d 156, 158 (Del. Ch. 1980); see also *Washington v. Harper*, 494 U.S. 210, 220-22 (1990) (considering patient's right to reject administration of antipsychotic drugs); *Winston v. Lee*, 470 U.S. 753, 758-59 (1985) (refusing to authorize surgery to obtain a bullet from a suspect); *Benson v. Terhune*, 304 F.3d 874, 884 (9th Cir. 2002) (affirming constitutional protections against unwanted medical treatment). Interestingly, in the recent litigation over the constitutionality of the Patient Protection and Affordable Care Act, the Solicitor General argued that "a requirement that individuals visit the dentist twice a year" would probably violate the Constitution. Reply Brief for Petitioner at 20, *Dep't Health & Human Servs. v. Florida*, 2012 WL 748426 (U.S. Mar. 7, 2012) (No. 11-398).

²⁴ See generally *Reikes v. Martin*, 471 So. 2d 385 (Miss. 1985) (clarifying proper jury requirements for testing informed consent); *Ross v. Hodges*, 234 So. 2d 905 (Miss. 1970) (ruling informed consent is satisfied even if physician fails to disclose certain information).

²⁵ See generally ALAN MEISEL & KATHY CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISION MAKING* ch.2 (3d ed. 2005 & Supp. 2013); CLAIRE C. OBADE, *PATIENT CARE DECISION MAKING: A LEGAL GUIDE FOR PROVIDERS* §§ 7:1-8:24 (1991 & Supp. 2012); FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* ch.7 (4th ed. 2007).

²⁶ See generally MEISEL & CERMINARA, *supra* note 25, at ch.4, 8; OBADE, *supra* note 25, §§ 9:1-11:11. I employ the term "surrogate" to refer to all those who are authorized to make health care decisions on behalf of the patient, whether appointed: by the patient herself (agents, surrogates), by a court (guardians, conservators), or by default legal rules (surrogates). Most patients are unable to communicate with providers at the time decisions are made about stopping life-sustaining medical treatment. See J. Randall Curtis, *Communicating about End-of-Life Care*, 20 *CRITICAL CARE CLINICS* 363, 364 (2004). Therefore, these decisions are usually made by surrogates.

²⁷ See generally MEISEL & CERMINARA, *supra* note 25, at ch.7; OBADE, *supra* note 25, at appendix A.

treatment.²⁸

Since the right to refuse life-sustaining treatment is well-established, patients can often enforce the right *ex ante* by obtaining injunctive or declaratory relief. Indeed, that is the procedural posture by which most right-to-die jurisprudence developed.²⁹ In *Quinlan*, for example, Karen Quinlan suffered irreversible brain damage resulting from respiratory failure.³⁰ She was soon diagnosed as being in a persistent vegetative state. Her family eventually decided to take her off the ventilator.³¹ But Karen's health care providers refused to comply, because they were concerned about criminal and other liability.³² The family litigated to the New Jersey Supreme Court to establish their right to refuse treatment on Karen's behalf.³³

This right to refuse life-sustaining treatment is most properly characterized as a "claim right" in the now-famous terminology of Wesley Hohfeld.³⁴ To say that a patient has a "right" is to say both that the patient has a "claim" against the clinician for x and that the clinician owes a correlative "duty" of x to the patient.³⁵ Or one might say that a

²⁸ See, e.g., *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1051-52 (Ohio App. 1984) (authorizing battery action for maintaining a patient in a persistent vegetative state ("PVS") on a respirator against her previously expressed wishes); *Miller v. HCA, Inc.*, No. 92-07830 (189th Dist. Ct., Harris Cty., Tex. Jan. 14, 1998) (awarding a \$60 million verdict for resuscitation of a newborn over family objections), *rev'd on other grounds*, 118 S.W.3d 758 (Tex. 2003); *Osgood v. Genesys Regional Med. Ctr.*, No. 94-26731-NH (Genesee Cty. Cir. Ct. Feb. 16, 1996) (awarding \$16.6 million when medical staff provided life-sustaining treatment to patient against her agent's demands); *Rodriguez v. Pino*, 634 So. 2d 681 (Fla. App. 1994); see also *Barriers to End of Life Care - Not in My ER, Not in My Nursing Home*, 11 L. & HEALTH CARE NEWSL. (U. of MD.), Spring 2004, at 16, 20 [hereinafter *Barriers*] (discussing a nursing home fined by Maryland state agency for not following resident's advance directive); Elena N. Cohen, *Refusing and Forgoing Treatment: Liability Issues*, in 3 TREATISE ON HEALTH CARE LAW §§ 18.07[1] & 18.07[2] nn.45-56 (Alexander M. Capron & Irwin M. Birnbaum eds., 2005) (collecting cites); Amy Lynn Sorrel, *Lawsuit Showcases DNR Liability Twist for Doctors*, AM. MED. NEWS, Feb. 5, 2007 (considering liability of doctors who do not follow advanced directives).

²⁹ *Rodriguez*, *supra* note 11, at 6.

³⁰ *In re Quinlan*, 348 A.2d 801, 811 (N.J. Super Ct. Div. 1975)

³¹ *Id.* at 813.

³² *Id.* at 814.

³³ *In re Quinlan*, 348 A.2d 801 (N.J. Super. Ct. Ch. Div. 1975), *rev'd*, 355 A.2d 647 (N.J. 1976).

³⁴ WESLEY N. HOHFELD, *FUNDAMENTAL LEGAL CONCEPTIONS AS APPLIED IN JUDICIAL REASONING AND OTHER LEGAL ESSAYS* 101 (Walter Wheeler Cook ed., 1919).

³⁵ See Thaddeus M. Pope & Douglas B. White, *Patient Rights*, in *OXFORD TEXTBOOK OF CRITICAL CARE* (2d ed. forthcoming 2013). In contrast, under France's 2005 law, a doctor must "consult" a patient's advance directive but is not obliged to "follow" it. Leo Wada, [*A Guide to Advance Health Care Directives*], 184 REVUE DE INFIRMIERE 31 (2012) (Fr.).

patient's "right" is a normative demand that imposes a constraint on the clinician.³⁶ Unfortunately, as demonstrated in the next section, clinicians frequently fail to fulfill their duty to honor their patients' right to refuse.

III. Problem of Unwanted Life-Sustaining Treatment

For twenty years, medical and legal commentators have described the problem of unwanted life-sustaining treatment. In this Section, I first review studies showing the prevalence of unwanted treatment. Second, I identify and describe the twelve main reasons that clinicians administer life-sustaining in contradiction to, and in violation of, their patient's wishes.

A. Prevalence of Unwanted Life-Sustaining Treatment

Over the past two decades, legal and medical commentators have consistently asserted that "patients are being saved against their will with some frequency."³⁷ Since the right to refuse life-sustaining treatment was both legally and ethically established by 1990, I review some of the key statistical measures from 1990 to 2010. The rates of clinician compliance with patient preferences are depressingly low. But, as I explain in the second half of this subsection, there is reason for optimism. Over just the past few years, the POLST paradigm has rapidly spread across the United States. POLST has proven effective at ensuring that the treatment patients want matches the treatment that those patients get.

1. First Twenty Years: 1990 to 2010

Commentators have almost uniformly concluded that clinicians are regularly administering life-sustaining treatment to patients that those patients do not want.³⁸

³⁶ GEORGE RAINBOLT, *THE CONCEPT OF RIGHTS* 25 (2006). The author states that the only relations that imply normative constraints are claims and immunities. *Id.* "If a rule system implies that a person has a duty or a disability, then her acts are restricted or constrained." *Id.* Normative constraints are different from logical or physical restraints, but still restrict or limit actions. *Id.* at 26.

³⁷ Holly Fernandez Lynch et al., *Compliance with Advance Directives: Wrongful Living and Tort Incentives*, 29 J. LEG. MED. 133, 177 (2008). Even with an advance directive that refuses medical care, some patient's wishes are not honored. *Id.*

³⁸ Peters, *supra* note 11, at 674. The author notes, "[o]verwhelming evidence indicates that physicians routinely ignore patient preferences about life-sustaining care." *Id.*; see also Annette M. Browning, *Moral Distress and Psychological Empowerment in Critical Care Nurses Caring for Adults at End of Life*, 22 AM. J. CRITICAL CARE 143, 147 (2013) (finding physicians frequently ignored absence

“[T]here do appear to be many cases in which patients are at risk of receiving treatment inconsistent with their previously stated wishes”³⁹ “[T]echnological advances are used too often to save the lives of those who do not want to be saved for fear of precisely the decline in quality of life they ultimately experience.”⁴⁰

Both law and practice support a presumption that each patient will receive aggressive interventions to prolong her/his life as long as possible. The patient can rebut this presumption and decline treatment, even if that choice hastens the patient’s death. But many patients lack the capacity to make health care decisions at the end of life. For decades, medical and legal experts have looked to the advance directive as a central mechanism for assuring that these patients are treated in accordance with their preferences.

Advance directives have been widely and heavily promoted and offered as a key means by which patients can avoid unwanted treatment.⁴¹ There has been a dramatically growing emphasis on advance care planning, exemplified by major national initiatives like National Healthcare Decisions Day⁴² and the Conversation Project.⁴³ Similar

or inadequacy of consent); Jonathan Rauch, *How Not to Die*, THE ATLANTIC, (April 24, 2013) at *2, <http://www.theatlantic.com/magazine/archive/2013/05/how-not-to-die/309277/> (“It happens all the time.”) (quoting Angelo Volandes). To be precise, most of the oft-cited evidence, as discussed below, does not directly establish that clinicians ignore patient preferences. It instead indicates that advance directives have little or no effect on outcome and process of care. This is not exactly the same thing. Moreover, the surveys on which these estimates are based are not representative. See T.R. Fried et al., *Understanding the Treatment Preferences of Seriously Ill Patients*, 346 NEW ENG. J. MED. 1061 (2002); M. Danis et al., *Patients' and Families' Preferences for Medical Intensive Care*, 260 JAMA 797 (1988).

³⁹ Joan M. Teno et al., *Do Formal Advance Directives Affect Resuscitation Decisions and the Use of Resources for Seriously Ill Patients?*, 5 J. CLINICAL ETHICS 23 (1994); Joan M. Teno, *The Wrongful Resuscitation*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, 2008, available at <http://www.webmm.ahrq.gov/case.aspx?caseID=175> (citing several studies); Alice Dembner, *'Do Not Resuscitate' Instructions often Ignored, Overlooked*, BOSTON GLOBE, Sept. 11, 2003, available at http://www.boston.com/news/local/articles/2003/09/11/do_not_resuscitate_instructions_ofte_n_ignored_overlooked/ (“A lot of people are getting care they don't want. I estimate it's occurring in one in 20 deaths.”) (quoting Joan Teno).

⁴⁰ Lynch et al., *supra* note 37, at 148.

⁴¹ See, e.g., Rebecca L. Sudore & Terri R. Fried, *Redefining the “Planning” in Advance Care Planning: Preparing for End-of-Life Decision Making*, 153 ANNALS INTERNAL MED. 256 (2010); W.F. Benson & N. Aldrich, *Advance Care Planning: Ensuring Your Wishes Are Known and Honored If You Are Unable to Speak for Yourself*, *Critical Issue Brief*, CENTERS FOR DISEASE CONTROL AND PREVENTION, 2012, available at

<http://www.cdc.gov/aging/pdf/advanced-care-planning-critical-issue-brief.pdf>.

⁴² See generally NATIONAL HEALTHCARE DECISIONS DAY, <http://www.nhdd.org/> (last visited

initiatives have been developed and implemented at the state and regional levels.⁴⁴ And new tools, like the “Prepare” website, are constantly being developed and launched.⁴⁵ Furthermore, innovation in the field of advance directives has not been limited to the private sector. Many states have considered innovative legislation to facilitate advance care planning.⁴⁶ And, at the federal level, there have been legislative and regulatory proposals to expand Medicare coverage of advance care planning.⁴⁷

But, despite all this outreach and education, advance directives have actually had rather little impact.⁴⁸ Cases of clinicians ignoring patient instructions are regularly reported in the mass media.⁴⁹ “Advance care directives correspond poorly with patient’s

Apr. 30, 2013) (emphasizing the importance of end-of-life care planning).

⁴³ See generally THE CONVERSATION PROJECT, <http://theconversationproject.org/starter-kit/intro/> (last visited Apr. 30, 2013) (helping people discuss their end-of-life care and wishes).

⁴⁴ See generally RESPECTING CHOICES, <http://respectingchoices.org/> (last visited Apr. 30, 2013) (notable recognized organization, Respecting Choices in La Crosse, Wisconsin).

⁴⁵ See generally PREPARE, <https://www.prepareforyourcare.org> (last visited Apr. 30, 2013) (helping individuals make informed decisions regarding their medical care).

⁴⁶ See Thaddeus M. Pope, *Legal Briefing: Advance Care Planning*, 20 J. CLINICAL ETHICS 362 (2009).

⁴⁷ See Personalize Your Care Act of 2013, H.R. 1173, 113th Cong. (1st Sess. 2013) available at <http://beta.congress.gov/113/bills/hr1173/113hr1173ih.pdf>; Thaddeus M. Pope & Melinda Hexum, *Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment*, 23 J. CLINICAL ETHICS 353, 369 (2012).

⁴⁸ See Lynch et al., *supra* note 37; Carl E. Schneider, *The Best Laid Plans*, 30 HASTINGS CENTER REP. 24, 24-25 (2000); E.H. Dobbins, *End-of-Life Decisions: Influence of Advance Directives on Patient Care*, 33 J. GERONTOLOGICAL NURSING 50 (2007); Thomas J. Prendergast, *Advance Care Planning: Pitfalls, Progress, Promise*, 29 CRITICAL CARE MED. N34 (2001); P.H. Ditto et al., *Advance Directives as Acts of Communication: A Randomized Trial*, 161 ARCHIVES INTERNAL MED. 421 (2001); Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249 (1997); David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 JAMA 2101 (1992); R. Sean Morrison et al., *The Inaccessibility of Advance Directives on Transfer from Ambulatory to Acute Care Settings*, 274 JAMA 478, 481 (1995) (finding treatment decisions made “without consulting the patient’s designated proxy or living will” in 75% of cases); Lawrence J. Schneiderman et al., *Effects of Offering Advance Directives on Medical Treatments and Costs*, 117 ANNALS 599 (1992); Peters, *supra* note 11, at 674 (“[P]atient preferences rarely affect treatment decisions.”).

⁴⁹ See, e.g., Susan Brink, *Living Wills Often Ignored*, MSNBC (Feb. 26, 2010), http://www.nbcnews.com/id/35610499/ns/health-health_care/#.USkW1aWJ940; Laura Parker, *In a Crisis, Do-Not-Revive Requests Don't Always Work*, USA TODAY, Dec. 19, 2006; Vigoda, *Life Support*, USA TODAY, Feb. 20, 1995, at 1D (explaining that 34% of physicians declined to withdraw treatment at patient or surrogate request); Ostrom, *Hospitals Don't Follow Living Wills*, DAYTON DAILY NEWS, Nov. 12, 1995, at 7A. As a further example, note that the National Confidential Enquiry into Patient Outcome and Death found that 52 patients who suffered a cardiac arrest in an NHS hospital over a two-week period in 2010 were resuscitated despite a DNR order. Jenny Hope, *Do Not Resuscitate Orders 'Ignored' as Doctors Try to Revive Patients Suffering*

care preferences.”⁵⁰ In one recent survey only 44% of family members agreed that their loved one’s wishes were “completely followed and honored.”⁵¹ Patient “wishes may or may not be honored.”⁵² Daniel Callahan observes that a “continuing problem with ‘living wills’ has been the unwillingness of many physicians to honor them.”⁵³ In short, the evidence indicates that clinicians “routinely fail to honor” advance directives.⁵⁴

A significant number of medical survey studies confirm the dismal rate of advance directive compliance.⁵⁵ One study found that clinicians overrode advance directives 25% of the time.⁵⁶ Another study found that only 58% of clinicians followed advance directives “most or all of the time.”⁵⁷ And a third study found that clinicians

Cardiac Arrest, DAILY MAIL, June 1, 2012.

⁵⁰ J. Andrew Billings, *The Need for Safeguards in Advance Care Planning*, 27 J. GEN. INTERNAL MED. 595, 596 (2012) (reviewing studies); Lauren G. Collins, *The State of Advance Care Planning One Decade after SUPPORT*, 23 AM. J. HOSPICE & PALLIATIVE CARE 378 (2006).

⁵¹ *Snapshot: Final Chapter: Californians’ Attitudes and Experiences with Death and Dying*, CALIFORNIA HEALTHCARE FOUNDATION 21, 30 (2012), available at <http://www.chcf.org/publications/2012/02/final-chapter-death-dying>.

⁵² Nicole Marie Saitta & Samuel D. Hodge, Jr., *Wrongful Prolongation of Life – A Cause of Action that Has Not Gained Traction Even Though a Physician Has Disregarded a ‘Do Not Resuscitate’ Order*, 30 TEMP. J. SCI. TECH. & ENVTL. L. 221, 238 (2011).

⁵³ DANIEL CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* 15 (1987).

⁵⁴ Daniel P. Hickey, *The Disutility of Advance Directives: We Know the Problems, But Are There Solutions*, 36 J. HEALTH L. 455 (2003); see, e.g., David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 JAMA 2101 (1992); see also Erin Webley, *Law, Insouciance, and Death in the Emergency Room*, 19 ELDER L.J. 257 (2011); Susan A. Channick, *The Myth of Autonomy at the End-of-Life: Questioning the Paradigm of Rights*, 44 VILL. L. REV. 577 (1999); Gasner, *supra* note 12, at 502; Jo Anne Herina Jeffreys, *Advance Directives: Are They Worth the Paper They’re Written On?*, 190 N.J. LAWYER 17 (1988).

⁵⁵ One study found that only 22% of patients had advance directives, and even when conditions for invocation were met, advance directives impacted care in fewer than 50% of cases. See generally L.L. Heintz, *Efficacy of Advance Directives in a General Hospital*, 56 HAW. MED. J. 203 (1997). Another study found that, “patients in the ICU are frequently incapacitated and family member(s) and/or the physician may override the advance directive requesting ‘DNR’ status.” CYNTHIA LYNN FERREL, *THE EXPERIENCE OF CRITICAL CARE NURSES IN INITIATING HOSPICE CARE* 5 (2007). For more, see, e.g., Susanna E. Bedell & Thomas L. Debanco, *Choices about CardioPulmonary Resuscitation in the Hospital*, 310 NEW ENG. J. MED. 1089 (1984) (finding that one-third of patients who were resuscitated did not want CPR); Richard F. Uhlmann et al., *Understanding of Elderly Patients’ Resuscitation Preferences by Physicians and Nurses*, 150 WEST J. MED. 705 (1989); S. Middlewood et al., *Dying in Hospital: Medical Failure or Natural Outcome?*, 22 J. PAIN & SYMPTOM MGMT. 1036 (2001); W.R. Mower & L.J. Baraff, 153 ARCHIVES INTERNAL MED. 375 (1993) (finding that advance directives alone are less honored than if supported by surrogate).

⁵⁶ Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 881, 882 (1991).

⁵⁷ Brenda Bergman-Evans et al., *Uncovering Beliefs and Barriers: Staff Attitudes Related to Advance*

deviate from patient instructions in 65% of cases, looking instead to prognosis, perceived quality of life, and family wishes.⁵⁸ Furthermore, even when clinicians do not directly and overtly override a known refusal, they often unknowingly ignore refusals by failing to read or consider the patient's instructions.⁵⁹

Perhaps the most significant and famous study of clinician compliance with patient instructions is SUPPORT, the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments.⁶⁰ A two-year observational study of over 4,000 patients found that a mere 47% of physicians knew their patients' preferences regarding avoiding, or consenting to, CPR. And for those patients who did have DNR orders, half were written within two days of death.⁶¹

A second phase of the SUPPORT study randomized nearly 5,000 patients to either a control group or to an intervention group.⁶² Patients in the intervention group received regular prognostic estimates of survival, CPR outcomes, and functional disability.⁶³ In addition, a specially-trained nurse maintained regular contact with the patient, family, physician, and hospital staff in order to: elicit preferences, improve understanding of outcomes, and facilitate advance care planning and patient-physician communication.⁶⁴ Unfortunately, the high intervention in this group failed to improve any of the measured outcomes.⁶⁵

Directives, 25 AM. J. HOSPICE & PALLIATIVE MED. 347 (2008).

⁵⁸ Steven B. Hardin & Yasmin A. Yusufaly, *Difficult End-of-Life Treatment Decisions: Do Other Factors Trump Advance Directives?*, 164 ARCHIVES INTERNAL MED. 1531 (2004).

⁵⁹ D.M. Westphal & S.A. McKee, *End-of-Life Decision Making in the Intensive Care Unit: Physician and Nurse Perspectives*, 24 AM. J. MED. QUALITY 222 (2009) (finding that only 53% of physicians read living wills).

⁶⁰ *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591, 1591 (1995).

⁶¹ *Id.* at 1594. (documenting the 'shortcomings in communication, frequency of aggressive treatment, and the characteristics of hospital death.').

⁶² *Id.* at 1596.

⁶³ *Id.* at 1592.

⁶⁴ *Id.* at 1591.

⁶⁵ *Id.* The study found that "Patients experienced no improvement in patient-physician communication...or in the five targeted outcome, i.e., incidence or timing of written DNR orders ... physician's knowledge of their patients' preferences not to be resuscitated...number of days spent in an ICU, receiving mechanical ventilation, or comatose before death...or reported level of pain." *Id.* Only 41% of patients believe that treatment reflected the preferences for palliative care over more aggressive interventions. K.E. Covinsky et al., *Communication and Decision Making in Seriously Ill Patients: Findings of the SUPPORT Project*, 48 J. AM. GERIATRICS SOC'Y S187 (2000).

A more recent survey was conducted by the Pennsylvania Patient Safety Authority (“PPSA”). The PPSA is an independent state agency charged with “taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety in hospitals” and certain other facilities.⁶⁶ The PPSA analyzed over 200 patient safety reports from 2004 to 2008, and found that approximately 1 in 5 involved patients that had received potentially unwanted treatments.⁶⁷

Unfortunately, the advance directive has had very limited success.⁶⁸ There are several reasons for this. First, many patients have not completed one. And most of the advance directives that have been completed are unavailable when needed.⁶⁹ Moreover, even if both of these hurdles are overcome, more remain. To implement patient preferences, advance directives must be reduced to medical orders. But advance directives are often vague, leaving providers uncertain as to how the instructions apply to the patient’s *current* clinical circumstances.⁷⁰ For example, take the phrase “if I am close to death:” does that mean within weeks, or within hours? Furthermore, even once orders are written, they often do not travel outside the institution.

⁶⁶ *Who We Are*, PENNSYLVANIA PATIENT SAFETY AUTHORITY, <http://patientsafetyauthority.org/Pages/WhoAreWe.aspx> (last visited Apr. 30, 2013).

⁶⁷ *Understanding Living Wills and DNR Orders*, PENNSYLVANIA PATIENT SAFETY AUTHORITY, 5(4) PENNSYLVANIA PATIENT SAFETY ADVISORY 111 (2008); see also Emir Festic et al., *Perspective of Physicians and Nurses Regarding End-of-Life Care in the ICU*, 7 J. INTENSIVE CARE MED. 45 (2012); SHANNON BROWNLEE, CALIFORNIA HEALTHCARE FOUNDATION, END-OF-LIFE CARE IN CALIFORNIA: YOU DON’T ALWAYS GET WHAT YOU WANT (April 2013) available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/E/PDF%20EOLWhatYouWant.pdf>.

⁶⁸ Lesley S. Castillo et al., *Lost in Translation: The Unintended Consequences of Advance Directives Law on Clinical Care*, 154 ANNALS INTERNAL MED. 121 (2011); Keith E. Sonderling, *POLST: A Cure for the Common Advance Directive – It’s Just What the Doctor Ordered*, 33 NOVA L. REV. 451 (2009); Marshall B. Kapp, *The Nursing Home as Part of the POLST Paradigm*, 36 HAMLINE L. REV. (forthcoming 2013), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2157497; Henry S. Perkins, *Controlling Death: The False Promise of Advance Directives*, 147 ANNALS INTERNAL MED. 51 (2007); Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 HASTINGS CENTER REP. 30 (2004).

⁶⁹ See *infra* notes 91-94 and accompanying text.

⁷⁰ See Christopher M. Burkle et al., *Physician Perspectives and Compliance with Patient Advance Directives: The Role External Factors Play on Physician Decision Making*, 13 BMC MED. ETHICS 31, *9 (2012). The study found that only 67% of physicians think that the phrase “no life support” in an advance directive should be interpreted literally. *Id.*

2. *Recent Improvements: POLST*

POLST helps address all of these problems.⁷¹ Meant to supplement, not replace, traditional advance directives for those patients expected to die within the next year, POLST has several advantages.⁷² First, POLST is signed by both the health care provider and the patient.⁷³ There is no need for interpretation and translation. POLST is an immediately actionable medical order.⁷⁴ Second, since POLST is on a single-page, standardized form, it is easy to follow.⁷⁵ Third, unlike DNR orders, POLST addresses not just CPR, but an entire range of life-sustaining interventions, such as IV fluids, antibiotics, a feeding tube, and artificial breathing.⁷⁶ Fourth, POLST is transportable.⁷⁷ It is a brightly colored, clearly identifiable form that remains in the patient's chart and travels with the patient, from hospital, to nursing home, to ambulance, to the patient's home.⁷⁸ POLST is recognized and honored across all these different treatment settings.⁷⁹

POLST protects and promotes patient autonomy better than advance directives in at least four ways. First, POLST is usually created with a health care provider at or near the time when an acute or serious chronic condition develops. It addresses the

⁷¹ Patricia A. Bomba et al., *POLST: An Improvement over Traditional Advance Directives*, 79 CLEVELAND CLINIC J. MED. 457, 457 (2012); C. Spillers & B. Lamb, *Is the POLST Model Desirable for Florida?*, 8 FLA. PUB. HEALTH REV. 80-90, 80 (2011); Pope & Hexum, *supra* note 47. However, without immunity, clinicians are reluctant to honor POLST. *See, e.g., Hearing on S.B. 5562 before the Washington Senate Health Care Committee* (Feb. 19, 2013) (video at 1:18:00).

⁷² *See* Bomba et al., *supra* note 71, at 457.

⁷³ *Id.* at 460-62. If the patient lacks capacity, the POLST is normally signed by the surrogate.

⁷⁴ *Id.* at 458-59.

⁷⁵ *Id.* at 462.

⁷⁶ *Id.* at 459.

⁷⁷ *Id.*

⁷⁸ *See* Bomba et al., *supra* note 71, at 459.

⁷⁹ For detailed explanations of POLST (customized for clinician, lawyer, and patient audiences in multiple languages) see the extensive training resources on the California, New York, Oregon, and West Virginia program websites. COALITION FOR COMPASSIONATE CARE OF CALIFORNIA, *POLST – Physician Orders for Life-Sustaining Treatment: For Health Care Providers*, <http://www.capolst.org/?for=providers> (last visited Apr. 30, 2013); Compassion and Support at the End of Life, *Medical Orders for Life-Sustaining Treatment – Professionals*, http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center (last visited Apr. 30, 2013); CENTER FOR HEALTH CARE ETHICS, OREGON HEALTH & SCIENCE UNIVERSITY, *Oregon POLST Information for Health Care Professionals, POLST*, <http://www.oregonpolst.org/oregon-polst-registry/health-care-professionals/> (last visited Apr. 30, 2013); WEST VIRGINIA CENTER FOR END OF LIFE CARE, *Information about Completing Effective POST Forms*, <http://www.wvendoflife.org/POST> (last visited Apr. 30, 2013).

patient's *current* situation, not a possible future scenario. Consequently, POLST has a greater chance of being more informed and more relevant to the specific medical situation at hand. Second, since the POLST form is highly visible, portable, and travels with the patient's medical records, it is more likely *available* at the time that a decision must be made. Third, since POLST is written in precise medical language on a standardized form, it is better *understood* by healthcare providers. Fourth, since POLST is signed by a provider, it has a greater chance of *compliance* by other providers.

While documentation is the centerpiece, POLST is more than just a form. It is really a tool that provides a framework for end-of-life care conversations between patients, their families, and their health care providers. Providers are encouraged to discuss specific scenarios and treatment options. Patients and families have the chance to ask questions and to make their wishes known.⁸⁰ In short, POLST gives patients more control over their end-of-life care. As a "universal medical order" that is honored across care facilities, POLST significantly changes how end-of-life treatment is provided. Health care providers know immediately what patients do and do not want. And they provide treatment and care consistent with those preferences.⁸¹

B. Twelve Leading Causes of Unwanted Life-Sustaining Treatment

Patients in the United States have the right to refuse life-sustaining treatment.⁸² But clinicians often fail to honor this right.⁸³ Here, I turn to examine the reasons and explanations for clinician noncompliance. Why are so many patients receiving so much unwanted treatment?

⁸⁰ Patricia A. Bomba, *Landmark Legislation in New York Affirms Benefits of a Two-Step Approach to Advance Care Planning Including MOLST: A Model of Shared, Informed Medical Decision-Making and Honoring Patient Preferences for Care at the End of Life*, 17 WIDENER L. REV. 475, 478 (2011).

⁸¹ B.J. Hammes et al., *The POLST Program: A Retrospective Review of the Demographics of Use and Outcomes in One Community Where Advance Directives Are Prevalent*, 15 J. PALLIATIVE MED. 77, 77 (2012); Susan E. Hickman et al., *The Consistency Between Treatments Provided to Nursing Facility Residents and Orders on the Physician Orders for Life-Sustaining Treatment Form*, 59 J. AM. GERIATRICS SOC'Y 2091-99, at 2 (2011); Susan E. Hickman et al., *A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program*, 58 J. AM. GERIATRICS SOC'Y 1241, at 2 (2010); Susan E. Hickman et al., *Use of the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm Program in the Hospice Setting*, 12 J. PALLIATIVE MED. 133, 133 (2009); M.A. Lee et al., *Physician Orders for Life-Sustaining Treatment (POLST): Outcomes in a PACE Program*, 48 J. AM. GERIATRICS SOC'Y 1219, at 2 (2000); Susan W. Tolle et al., *A Prospective Study of the Efficacy of the Physician Order Form for Life-Sustaining Treatment*, 46 J. AM. GERIATRICS SOC'Y 1097, at 2 (1998).

⁸² See *supra* text accompanying notes 19-25.

⁸³ See *supra* text accompanying notes 37-40, 48-70.

There are twelve leading causes of unwanted treatment: (1) inadequate advance care planning; (2) clinician misinterpretation of, and confusion on, advance directives; (3) uncertain validity of advance directives; (4) uncertain application of advance directives; (5) demanding and conflicting surrogates; (6) uncertain status of the surrogate decision maker; (7) uncertain patient decision making capacity; (8) inadequate informed consent; (9) negligent maintenance of medical records; (10) vitalistic philosophy of medicine; (11) conscience-based objections; and (12) financial incentives.

1. *Inadequate Advance Care Planning*

Many decisions about life-sustaining treatment concern patients who have lost decision-making capacity.⁸⁴ These patients cannot personally and legally refuse treatment at the time its use becomes necessary. Consequently, refusal must be made ahead-of-time. A traditional means for doing this is with an advance directive.

Unfortunately, most Americans have not completed advance directives. Two 2012 surveys show completion rates of just 23%⁸⁵ and 24%, respectively.⁸⁶ Several other recent surveys show similar low completion rates of 35%⁸⁷ and 33%, respectively.⁸⁸ On the other hand, some surveys show higher completion rates, for example, of 60%.⁸⁹ Further, completion rates are higher among some populations. For example, more than 50% of nursing home residents have advance directives, and that

⁸⁴ See, e.g., J. Randall Curtis & Mark R. Tonelli, *Shared Decision-Making in the ICU: Value, Challenges, and Limitations*, 183 AM. J. RESPIRATORY & CRITICAL CARE MED. 840, 840 (2011). “In the ICU, decision-making often involves surrogate decision-makers, since patients frequently lack decision-making capacity due to their severity of illness.” *Id.*

⁸⁵ CALIFORNIA HEALTHCARE FOUNDATION, *supra* note 51 (demonstrating percentage of California adults who have engaged in end of life planning).

⁸⁶ Stacy M. Fischer et al., *Advance Directive Discussions: Lost in Translation or Lost Opportunities?*, 15 J. PALLIATIVE MED. 86, 86 (2012) (drawing from cross-sectional study of adult patients admitted for medical care in Denver area).

⁸⁷ Susan L. Schrader et al., *South Dakota's Dying to Know: A Statewide Survey about End of Life*, 12 J. PALLIATIVE MED. 695, 699 (2009).

⁸⁸ NEBRASKA HOSPICE & PALLIATIVE CARE ASSOCIATION, *Nebraska End-of-Life Survey Report*, at *8 (Nov. 2011), *available at*

<http://www.nehospice.org/associations/6715/files/EOLSurveyBooklet2011.pdf>.

⁸⁹ THOMSON-REUTERS, *National Survey of Healthcare Consumers: End-of-Life Care*, at *4 (July 2010), *available at*

http://www.factsforhealthcare.com/pressroom/NPR_report_EndofLifeCare0710.pdf. The survey demonstrates advance planning at rates of 80% for those over 65 and 40% for those under 35. *Id.*

rate jumps to 77% for nursing home residents over age 85.⁹⁰ Still, the vast majority of Americans have failed to make their preferences and choices known either informally to family members or through a formal written instrument.

Even when patients do complete advance directives, they are often not available when needed.⁹¹ Physicians are frequently unaware of the existence of their patients' advance directives.⁹² Since advance directives are regularly signed years before they are used, their existence and location often "vanish in the mists of time."⁹³ Indeed, fewer than 30% of completed advance directives are recorded in patients' charts.⁹⁴

Why would the nonexistence or unavailability of an advance directive cause the patient to receive unwanted treatment? Three factors combine to produce this result. First, when the patient has not declared the treatment to be unwanted, it is presumed that it is wanted.⁹⁵ End-of-life medicine is like a "train" that will proceed to the final stop, unless the patient has a valid "ticket" to disembark at an earlier station. Second, as a result of inertia instead of a deliberate choice, most patients have failed to rebut the presumption. Third, application of this presumption is often wrong.

Robust survey evidence shows that most people would not want to continue life-sustaining treatment in the face of serious illness.⁹⁶ In one recent survey, 67% would prefer to "die a natural death" if their heartbeat or breathing stopped while only

⁹⁰ Adrienne L. Jones et al., *Use of Advance Directives in Long-term Care Populations*, 54 NCHS DATA BRIEF 1, 1-2 (Jan. 2011), available at <http://www.cdc.gov/nchs/data/databriefs/db54.pdf>.

⁹¹ U.S. DEPT OF HEALTH & HUMAN SERV., *Advance Directives and Advance Care Planning: Report to Congress*, 24-25 (August 2008), available at <http://aspe.hhs.gov/daltcp/reports/2008/ADCongRpt.pdf> [hereinafter DHHS].

⁹² R.F. Johnson et al., *Advance Directives in the Medical Intensive Care Unit of a Community Teaching Hospital*, 107 CHEST J. 752, 755 (1995).

⁹³ Fagerlin & Schneider, *supra* note 68, at 35.

⁹⁴ R.S. Morrison et al., *The Inaccessibility of Advance Directives on Transfer from Ambulatory to Acute Care Settings*, 274 JAMA 478, 480 (1995); U.S. Living Will Registry Fact Sheet, U.S. LIVING WILL REGISTRY, <http://www.uslivingwillregistry.com/factsheet.shtml> (last visited Apr. 30, 2013).

⁹⁵ Wendy G. Anderson et al., *Code Status Discussions Between Attending Hospitalist Physicians and Medical Patients at Hospital Admission*, 26 J. GEN. INTERNAL MED. 359, 364 (2011); available at <http://www.readcube.com/articles/10.1007/s11606-010-1568-6>.

⁹⁶ See DHHS, *supra* note 91, at viii (discussing necessity of advance directives to prevent unwanted life-saving care for terminal patients). Indeed, application of the presumption is so often wrong that some have cogently argued that the presumption should be reversed. We should, they argue, presume that patients do *not* want life-sustaining treatment in catastrophic circumstances and permit patients to opt out if they are in the minority that wants treatment. In contrast, the status quo presumes that patients *want* treatment unless they opt out to refuse it. See James Lindgren, *Death by Default*, 56 L. & CONTEMP. PROBS. 185, 185-86 (1993).

7% would want medical providers to “use everything to prolong life.”⁹⁷ In another survey, 71% of individuals agreed that it is “more important to enhance the quality of life for seriously ill patients, even if it means a shorter life.”⁹⁸ In short, we know statistically that most patients do not want aggressive interventions at the end of life.⁹⁹ Yet, most of these patients get precisely that treatment they do not want, because they never adequately “told” anyone that they did not want it.

2. *Clinician Misinterpretation of, and Confusion on, Advance Directives*

Even when the patient has completed an advance directive and it is available, clinicians often misinterpret the advance directive to mean something not intended by the patient.¹⁰⁰ In fact, “nearly half of health professionals misunderstand the components of [advance directives].”¹⁰¹ Around 20% of health professionals would treat a patient contrary to the patient’s instructions and defibrillate a patient with a clear DNR order.¹⁰²

Clinician confusion on advance directives is both widespread and significant. For example, in one study of 768 physicians in 34 states, 78% of clinicians misinterpreted advance directives, thinking that the presence of an advance directive automatically means that the patient is DNR.¹⁰³ In fact, a patient may or may not refuse CPR in her advance directive.¹⁰⁴ Similar percentages of clinicians assumed that patients

⁹⁷ CALIFORNIA HEALTHCARE FOUNDATION, *supra* note 51, at 10.

⁹⁸ NAT’L J. & THE REGENCE FOUND., *LIVING WELL AT THE END OF LIFE: A NATIONAL CONVERSATION 3* (2011), available at <http://syndication.nationaljournal.com/communications/NationalJournalRegenceToplines.pdf>.

⁹⁹ See *supra* notes 95-97 and accompanying text. Additionally, although 70% of people say they would like to die at home, only 25% do. *Frontline, Facing Death: Facts and Figures* (PBS television broadcast Nov. 23 2010), available at <http://www.pbs.org/wgbh/pages/frontline/facing-death/facts-and-figures/> (last visited Apr. 30, 2013).

¹⁰⁰ See Fagerlin & Schneider, *supra* note 68, at 36-37; ECRI INSTITUTE & ISMP, PENNSYLVANIA PATIENT SAFETY AUTHORITY, *Understanding Living Wills and DNR Orders*, 5 PA. PATIENT SAFETY ADVISORY 111, 112-14 (2008), available at [http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2008/Dec5\(4\)/Documents/dec;5\(4\).pdf](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2008/Dec5(4)/Documents/dec;5(4).pdf); see also Alicia Gallegos, *Clearing Up Confusion on Advance Directives*, AM. MED. NEWS, Oct. 29, 2012, available at <http://www.ama-assn.org/amednews/2012/10/29/prsa1029.htm>.

¹⁰¹ Gallegos, *supra* note 100; see also Ferdinando L. Mirarchi et al., *TRLAD III: Nationwide Assessment of Living Wills and Do Not Resuscitate Orders*, 42 J. EMERGENCY MED. 511, 512 (2012).

¹⁰² Gallegos, *supra* note 100.

¹⁰³ Gallegos, *supra* note 100; Mirarchi, *supra* note 101, at 515.

¹⁰⁴ See Gallegos, *supra* note 100.

with a DNR order means “do not treat.”¹⁰⁵ In reality, DNR refers only to CPR and not to other medical interventions.¹⁰⁶

3. *Uncertain Validity of Advance Directive*

Another reason that clinicians may not comply with a patient’s advance directive is because they doubt its validity. Understandably, clinicians need not, and should not, comply with an advance directive that is technically deficient or inoperative under the relevant state statute.¹⁰⁷ Indeed, the clinician does not even need to be correct about the deficiency. It is sufficient that the clinician has a “good faith belief” in the advance directive’s invalidity.¹⁰⁸

For example, in *First Health Care Corporation v. Rettinger*, a nursing home refused to remove a resident’s feeding tube at the direction of his wife.¹⁰⁹ A court later ordered the tube removed.¹¹⁰ Subsequently, in defending against recovery of expenses incurred by the nursing home, the resident’s wife argued that those expenses would never have been incurred had the nursing home removed the tube when she first requested.¹¹¹ However, the nursing home successfully argued that it could not have complied with the wife’s earlier direction, because the resident’s living will was invalid.¹¹²

¹⁰⁵ Ferdinando L. Mirarchi, *Understanding Advance Directives: What Do DNR Orders Really Mean?*, QUANTIAMD, https://secure.quantiamd.com/home/understanding_advance_directives (last visited Apr. 30, 2013); see also Gallegos, *supra* note 100 (explaining clinicians often believe DNR patients should receive less care than designated by the order).

¹⁰⁶ See Joseph L. Breault, *DNR, DNAR, or AND? Is Language Important?*, 11 OCHSNER J. 302, 303 (2011), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3241061/>.

¹⁰⁷ See *McCroskey v. Univ. Tennessee*, No. 03A01-9409-CV-00356, 1995 WL 329133, *3 (Tenn. App. 1995). Of course, the clinician may ignore a surrogate’s instruction when, because of the surrogate’s status and/or the patient’s condition, the surrogate lacks the right under state law to refuse. See, e.g., *Montalvo v. Borkovec*, 647 N.W.2d 413, 419-21 (Wis. App. 2002) (denying parents right to refuse because child was not in a persistent vegetative state); *Cruzan v. Dir., Mo. Dep’t Health*, 497 U.S. 261, 268-87 (1990) (denying family right to refuse without clear and convincing evidence). The focus of this article is on clinicians ignoring *valid* refusals.

¹⁰⁸ See, e.g., N.Y. PUB. HEALTH L. 29B § 2974 (McKinney 2012 & Supp. 2013); see also, e.g., CAL. PROB. CODE § 4740(b) (West 2009). “A health care provider . . . is not subject to civil or criminal liability or to discipline for unprofessional conduct for . . . [d]eclining to comply with a health care decision of a person based on a belief that the person then lacked authority.” *Id.* For example, providers have significant uncertainty regarding the legality of a patient refusing oral food and fluid. See Pope & Anderson, *supra* note 20.

¹⁰⁹ *First Health Care Corp. v. Rettinger*, 456 S.E.2d 347, 348 (N.C. 1995).

¹¹⁰ *Id.* at 368-49.

¹¹¹ *Id.* at 350-51.

¹¹² *Id.* at 352 (Walker, J., dissenting), *rev’d by First Healthcare Corp. v. Rettinger*, 467 S.E.2d 243

4. *Uncertain Applicability of Advance Directive*

Even when the patient has sufficiently completed a valid advance directive, meaning it is available and has not been misinterpreted, it still might be unclear whether the advance directive applies to the situation at hand.¹¹³ After all, “advance directives are typically not entirely clear and decisive in their application for a particular choice about the patient’s care.”¹¹⁴ Even the most thoughtful and diligent clinician may be unable to confidently determine how to apply many advance directives.

There are four main reasons that it might be unclear whether or how the patient’s advance directive applies to the circumstances at hand. First, the advance directive may be hard to read. Second, it might be unclear if one of the requisite “triggering” conditions has obtained. Third, it might be unclear whether instructions, written in contemplation of one set of circumstances, apply to the patient’s now very different circumstances. Fourth, there are two special situations in which clinicians doubt that the advance directive should apply: iatrogenic cardiac arrest and suicide attempts.

(a) Poor Readability

The language of advance directives is notoriously vague.¹¹⁵ For example, the patient may decline “heroic measures” or “extraordinary treatment.” The courts are sometimes asked to interpret this sort of language. For example, in January 2009, S.S.

(2006) (following Judge Walker’s dissent to find the living will invalid).

¹¹³ Bergman-Evans, *supra* note 57, at 350 (25% of respondents said the reason advance directives were not followed was “the relevance of the [advance directive] was unclear to the present condition”); see generally N.G. Levinsky, *The Purpose of Advance Medical Planning – Autonomy for the Patients or Limitation of Care?*, 335 NEW ENG. J. MED. 741 (1996); Gary S. Fischer et al., *Can Goals of Care Be Used to Predict Intervention Preferences in an Advance Directive?*, 157 ARCHIVES INTERNAL MED. 801 (1997) (arguing that advance directives are “difficult to apply in specific clinical situations”); Billings, *supra* note 50, at 597 (arguing to “err on the side of preserving life” whenever the advance directive “does not convincingly address the current clinical situation”); A.S. Brett, *Limitations of Listing Specific Medical Interventions in Advance Directives*, 266 JAMA 825 (1991) (arguing that advance directives do not provide clinically relevant information); Joan M. Teno, *Role of Written Advance Directives in Decision Making: Insights from Qualitative and Quantitative Data*, 13 J. GEN. INTERNAL MED. 439 (1998).

¹¹⁴ Joanne Lynn et al., *Dementia and Advance Care Planning: Perspectives from Three Countries on Ethics and Epidemiology*, 10 J. CLINICAL ETHICS 271 (1999).

¹¹⁵ See Norman L. Cantor, *Making Advance Directives Meaningful*, 4 PSYCHOL. PUB. POL’Y & L. 629, 631-32 (1998); Leslie Castillo et al., *supra* note 68, at 121-22; Fagerlin & Schneider, *supra* note 68, at 35-36.

completed an advance directive, writing “I wish to live” in the “Optional Instructions” section.¹¹⁶ Just weeks later, a dispute erupted between S.S.’s wife and his siblings over how to apply the advance directive.¹¹⁷ On the one hand, this language seems to indicate some sort of vitalist statement. But after reviewing extensive testimony and other evidence, the court found that it simply meant that “S.S. wanted to live life to the fullest, not to merely exist, unable to communicate and interact with his family and friends.”¹¹⁸

(b) Unclear Triggering Condition

Many advance directives, often as a requirement of state law, condition their effectiveness on the satisfaction of a triggering condition. For example, the patient may instruct: “if I am in a permanent vegetative state, then I do not want a ventilator” or “if I am terminally ill, then I do not want artificial nutrition and hydration.”

Clinicians sometimes refuse to comply with an advance directive, because they are unsure whether the triggering event has obtained.¹¹⁹ For example, in *Wright v. Johns Hopkins Health Systems*, Robert Lee Wright was suffering from AIDS and, in turn, completed an advance directive.¹²⁰ In July of 1994, Wright was at Johns Hopkins Hospital for treatment of kidney problems when he suffered a cardiac arrest.¹²¹ Hospital staff performed CPR, saving Wright’s life.¹²² But he apparently suffered brain damage during the cardiac arrest.¹²³ After he awoke from a brief coma he could only moan and call for his mother.¹²⁴ Wright died ten days after the administration of CPR.¹²⁵

Wright’s parents sued Johns Hopkins Hospital, alleging that his living will had instructed that he not be treated aggressively, and that hospital staff should have sought their permission before resuscitating him.¹²⁶ But since no doctors had yet certified

¹¹⁶ S.I. v. R.S., 877 N.Y.S.2d 860, 864 (N.Y. Sup. Ct. 2009).

¹¹⁷ *Id.* at 864-66.

¹¹⁸ *Id.* at 866.

¹¹⁹ *Wright v. Johns Hopkins Health Sys. Corp.*, 728 A.2d 166, 175 (Md. 1999) (no certification that patient was terminal); *accord* *Allore v. Flower Hosp.*, 699 N.E.2d 560, 562 (Ohio Ct. App. 1997).

¹²⁰ *Wright*, 728 A.2d at 167.

¹²¹ *Id.* at 172.

¹²² *Id.* at 173.

¹²³ *Id.* at 172.

¹²⁴ *Wright*, 728 A.2d at 172.

¹²⁵ *Id.*

¹²⁶ *Id.* at 173.

Wright as terminally ill, his directives were not yet effective at the time he underwent the blood transfusion and cardiac arrest in the hospital.¹²⁷

Clinicians have good reason to be cautious. For example, in *Estate of Maxey v. Darden*, the Nevada Supreme Court held that clinicians may have improperly determined that the patient was “terminally ill.”¹²⁸ The court concluded that since the state’s healthcare decisions act imposes a duty to act in accord with reasonable medical standards when determining the patient’s status, an attending physician’s determination that a patient is terminally ill is subject to judicial review.¹²⁹ “[O]nly if the physician acts in accord with such standards is he or she entitled to immunity from civil liability.”¹³⁰

(c) Different Circumstances

Unlike POLSTs which are written for patients expected to die within the next year, advance directives are often written years in advance of when they are used.¹³¹ Consequently, the patient often writes her advance directive without contemplating the precise circumstances in which she later finds herself.¹³² Indeed, given the wide range of potential situations, no one could possibly anticipate more than a small subset of potential permutations. Moreover, the applicability of advance directives is thrown even further into doubt by the fact that many patients change their mind over time.¹³³

¹²⁷ *Id.* at 174.

¹²⁸ *Estate of Maxey v. Darden*, 187 P.3d 144, 152 (Nev. 2008).

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ See Burkle et al., *supra* note 70 (finding “Eighty percent [of physicians] reported they were likely to honor a patient’s [advance directive] despite its 5 year age”).

¹³² See, e.g., *Werth v. Taylor*, 475 N.W.2d 426, 429 (Mich. App. 1991) (dismissing battery claim by Jehovah’s Witness, because refusal was made in contemplation of routine elective surgery not with awareness that death might result); see also *In re T* [1993] Fam 95 (CA) (similar); *Matter of Hughes*, 611 A.2d 1148 (N.J. Super. Ct. App. Div. 1992); *University of Cincinnati Hosp. v. Edmond*, 506 N.E.2d 299 (Ohio 1986); *In re Estate of Dorone*, 534 A.2d 452 (Pa. 1987).

¹³³ See Joan M. Teno, *Advance Directives: Time to Move On*, 141 ANNALS INTERNAL MED. 159 (2004); R.M. Gready et al., *Actual and Perceived Stability of Preferences for Life-Sustaining Treatment*, 11 J. CLINICAL ETHICS 334 (2000); P.H. Ditto et al., *Advance Directives as Acts of Communication: A Randomized Trial*, 161 ARCHIVES INTERNAL MED. 421, 428 (2001); Lockhart, *The Stability of Older Adults’ Judgments of Fates Better and Worse than Death*, 25 DEATH STUDIES 299 (2001); Angela Fagerlin et al., *The Use of Advance Directives in End-of-Life Decision Making*, 46 AM. BEHAVIORAL SCIENTIST 268 (2002); Emily Clough, *A Critique of Advance Directives and Advance Directives Legislation*, 11 APPEAL REV. CURRENT L. & L. REFORM 16, 29-30 (2006); T.R. Fried et al., *Inconsistency over Time in the Preferences of Older Persons with Advanced Illness for Life-Sustaining Treatment*, 55 J. AM. GERIATRICS SOC’Y 1007 (2007); Rebecca L. Sudore & Terri R. Fried, *Redefining the “Planning” in Advance Care Planning: Preparing for End-of-Life Decision Making*, 153 ANNALS

The case of H.E. crisply illustrates the inapplicability of an advance directive, because of the patient's materially changed circumstances.¹³⁴ Years before her current hospitalization, H.E. completed an advance directive refusing blood products based on her Jehovah's Witness faith.¹³⁵ But since the time that H.E. completed the advance directive, she became engaged to a Muslim man and had promised to convert from being a Jehovah's Witness into a Muslim.¹³⁶ The premises on which H.E. wrote her advance directive were no longer valid for her.

(d) Iatrogenic Arrests

One particularly well-discussed situation in which clinicians think that advance directives or DNR orders should be ignored is when a cardiac arrest is iatrogenic, meaning it is induced by the therapeutic effort itself. This often happens in the operating room.¹³⁷

Clinicians often override DNR orders after an iatrogenic arrest.¹³⁸ For example, in one survey of approximately 200 anesthesiologists, nearly two-thirds unilaterally

INTERNAL MED. 256 (2010); JEROME GROOPMAN & PAMELA HARTZBAND, YOUR MEDICAL MIND: HOW TO DECIDE WHAT IS RIGHT FOR YOU (2011); Jerome Groopman & Pamela Hartzband, *Why Do Patients Often Deviate from their Advance Directives?*, KEVINMD.COM (Sept. 24, 2012), <http://www.kevinmd.com/blog/2012/09/patients-deviate-advance-directives.html>.

¹³⁴ HE v. Hosp. NHS Trust [2003] EWHC 1017 (Fam).

¹³⁵ *Id.* at [4].

¹³⁶ *Id.* at [13].

¹³⁷ See, e.g., Andrew J. Redman et al., *Use of Advance Directives for High-Risk Operations: A National Survey of Surgeons*, 255 ANNALS SURGERY 418 (2012); David B. Waisel, *Guidelines for Perioperative Do-Not-Resuscitate Policies*, 14 J. CLINICAL ANESTHESIA 467 (2002); Cynthia B. Cohen & Peter J. Cohen, *Do-Not-Resuscitate Orders in the Operating Room*, 325 NEW ENG. J. MED. 1879 (1991); M. Ewanchuk & P.G. Brindley, *Perioperative Do-Not-Resuscitate Orders—Doing 'Nothing' when 'Something' Can Be Done*, 10 CRITICAL CARE 219 (2006).

¹³⁸ See generally Margaret L. Schwarze et al., *Surgeons Expect Patients to Buy-in to Postoperative Life-Support Preoperatively" Results of a National Survey*, 41 CRITICAL CARE MED. 1 (2013); Margaret L. Schwarze et al., *The Role of Surgical Error in Withdrawal of Postoperative Life Support*, 256 ANNALS SURGERY 10 (2012); Laine Friedman Ross, *DNR orders and Iatrogenic Arrests During Dialysis: Should "No" Mean "No"?*, 16 SEMINARS DIALYSIS 395 (2003); David J. Casarrett et al., *Would Physicians Override a Do-Not-Resuscitate Order When a Cardiac Arrest is Iatrogenic?*, 14 J. GEN. INTERNAL MED. 35 (1999) (discussing survey concerning likelihood that physicians would override a DNR when hypothetical cardiac arrest is iatrogenic); Robert D. Truog et al., *DNR in the OR: A Goal-Directed Approach*, 90 ANESTHESIOLOGY 289 (1999); David J. Cassarett & Laine F. Ross, *Overriding a Patient's Refusal of Treatment after an Iatrogenic Complication*, 336 NEW ENG. J. MED. 1908 (1997); Nicholas A. Christakis & David A. Asch, *Biases in How Physicians Choose to Withdraw Life Support*, 342 LANCET 642 (1993).

“assumed” that the patients’ DNR orders were suspended in the perioperative period. Only half discussed this assumption with the patient or surrogate.¹³⁹ Like surgeons and anesthesiologists, other clinicians, like radiologists, may decide to ignore patients’ DNR orders, because if “arrest occurs as a direct or indirect result of a radiologic procedure, radiologists believe they are responsible for the situation.”¹⁴⁰

(e) Suicide Attempts

In September 2007, 26-year-old Kerrie Woollorton, depressed over her inability to have children, attempted suicide by drinking anti-freeze.¹⁴¹ She then called an ambulance and was transported to Norfolk and Norwich University Hospital.¹⁴² She arrived holding a “living will” in which she stated she did not want to be saved and was “100 per cent aware of the consequences.”¹⁴³ She was alert and verbally confirmed the written instructions.¹⁴⁴ Ms. Woollorton explained that calling for an ambulance was not a plea for treatment.¹⁴⁵ She just did not want to die alone and in pain.¹⁴⁶

Clinicians honored Ms. Woollorton’s refusal, fearing that they would be charged with assault if they treated her.¹⁴⁷ She died.¹⁴⁸ The case proved enormously controversial.¹⁴⁹ But in late 2009, the coroner determined that the hospital acted appropriately.¹⁵⁰ The coroner concluded that Ms. Woollorton “had capacity to consent

¹³⁹ M.V. Clemency et al., *Do Not Resuscitate (DNR) Orders and the Anesthesiologist: A Survey*, 76 ANESTHESIA ANALGESIA 394 (1993).

¹⁴⁰ Leonard Berlin, *Malpractice Issues in Radiology*, 174 AM. J. ROENTGENOLOGY 1513 (2000).

¹⁴¹ Rebecca Smith et al., *Suicide Woman Allowed to Die because Doctors Feared Saving Her Would be Assault*, TELEGRAPH, Sep. 30, 2009, <http://www.telegraph.co.uk/health/6248646/Suicide-woman-allowed-to-die-because-doctors-feared-saving-her-would-be-assault.html>.

¹⁴² *Id.* She had attempted suicide on several prior occasions. *Id.* Each time, she accepted dialysis treatment to flush the toxic solution from her system. *Id.*

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ Smith et al., *supra* note 141.

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*; see also K.L. Koenig & A. Salvucci, *Should We Honor Prehospital DNR Orders in Patients Who Attempt Suicide?*, 16 J. EMERGENCY MED. 761 (1998); Christopher J. Ryan & Sascha Callaghan, *Legal and Ethical Aspects of Refusing Medical Treatment after a Suicide Attempt: the Woollorton Case in the Australian Context*, 193 MED. J. AUSTRALIA 239 (2010); Sascha Callaghan & Christopher James Ryan, *Refusing Medical Treatment after Attempted Suicide: Rethinking Capacity and Coercive Treatment in Light of the Kerrie Woollorton Case*, 18 J. L. & MED. 811 (2011); Sajid Muzaffar, *To Treat or Not to Treat: Kerrie Woollorton, Lessons to Learn*, 28 EMERGENCY MED. J. 741 (2011).

¹⁵⁰ Clare Dyer, *Coroner Rules that Treating 26 Year Old Woman Who Wanted to Die Would Have Been*

to treatment which, more likely than not, would have prevented her death. She refused such treatment in full knowledge of the consequences and died as a result.”¹⁵¹

But the Woollorton case was controversial precisely because it is the exception to the rule. As a rule, clinicians do not honor treatment refusals linked to suicide attempts.¹⁵² They assume, often correctly, that the person is suffering from a mental illness that impairs judgment.¹⁵³

5. *Demanding or Conflicting Surrogates*

Yet another situation in which clinicians often provide unwanted life-sustaining treatment is at the demand of the patient’s own surrogate. The first four causes of unwanted life-sustaining treatment pertain to challenges with advance directives. But even if a patient has an advance directive refusing treatment, advance directives are rarely self-executing.¹⁵⁴ Clinicians usually turn to the patient’s surrogate for direction. But, notwithstanding the patient’s clear intent in the advance directive to refuse treatment, the surrogate often wants to continue treatment.¹⁵⁵

In such conflict situations, clinicians are overwhelmingly prepared to override the patient’s advance directive at the surrogate’s request.¹⁵⁶ “A choice between the

Unlawful, 339 BRITISH MED. J. 824 (2009), available at <http://www.bmj.com/content/339/bmj.b4070> (last visited Apr. 30, 2013).

¹⁵¹ *Id.*

¹⁵² See C.M.A. Geppert, *Saving Life or Respecting Autonomy: The Ethical Dilemma of DNR Orders in Patients Who Attempt Suicide*, 7(1) INTERNET J. L. HEALTHCARE & ETHICS (2011), available at <http://www.ispub.com/journal/the-internet-journal-of-law-healthcare-and-ethics/volume-7-number-1/saving-life-or-respecting-autonomy-the-ethical-dilemma-of-dnr-orders-in-patients-who-attempt-suicide.html#sthash.170eMsoF.dpbs> (last visited Apr. 30, 2013); see also Ryan & Callaghan, *supra* note 149, at 239.

¹⁵³ See *supra* note 152.

¹⁵⁴ See *supra* notes 113-33 and accompanying text. But see N.Y. PUB. HEALTH L. § 2994-D(3)(A)(II) (presuming that advance directives can be implemented automatically without consulting an agent or surrogate: “[N]othing in this article shall obligate . . . providers to seek the consent of a surrogate if an adult patient has already made a decision . . . in writing.”).

¹⁵⁵ See Thaddeus M. Pope, 3 ST. LOUIS U. J. HEALTH L. & POL’Y 108 (2010) (collecting authority); see also *In re Pinette*, No. 48-20040MH-1519-O (Fla. Cir. Ct. Nov. 23, 2004). Plus many surrogates are willing to have it overridden. Carl Schneider, *Liability for Life*, 34 HASTINGS CENTER REP. 10, 11 (2004).

¹⁵⁶ See Bergman-Evans, *supra* note 57, at 350. 63% of respondents said the reason advance directives were not followed was “conflict in family with expressed wishes of the [advance directive].” *Id.*; see Burkle et al., *supra* note 70, at *4 (finding physicians more likely to not honor advance directive due to “fear of liability”); Blake Sypher et al., *Autonomy, Informed Consent and*

liability risk posed by an emotionally distraught family . . . and that posed by a vegetative patient who will never regain consciousness is not much of a choice.”¹⁵⁷ And liability is not the clinician’s only concern. Even prevailing parties pay transaction costs. An angry surrogate’s action, “even if frivolous will cost the provider in legal fees, stress, and perhaps even professional reputation.”¹⁵⁸

Furthermore, clinicians may bend not only to demanding surrogates, but also to conflicting surrogates. When the patient’s potential surrogates cannot agree on a decision or plan, the clinician may be hesitant to stop life-sustaining treatment.¹⁵⁹ Clinicians err on continuing treatment when surrogates provide no clear direction, preferring to wait until consensus develops.¹⁶⁰

6. *Uncertain Status of the Surrogate Decision Maker*

Just as clinicians may refuse to comply with an advance directive because they doubt its validity,¹⁶¹ clinicians may refuse to comply with the treatment decisions of a

Advance Directives: A Study of Physician Attitudes, 101 W.V. MED. J. 131, 133 (2005). 40% of 90 surveyed physicians would override advance directive based on the surrogate’s demand, and 6% would for “purely paternalistic reasons.” *Id.*; Renee Martin, *Liability for Failing to Follow Advance Directive*, PHYSICIAN’S NEW DIGEST (1999).

¹⁵⁷ Justin Waddell, *Dead Letters: Protecting the Intentions of a Living Will Declarant with a Dedicated Advocate*, 25 GEO. J. LEGAL ETHICS 801, 807 (2012); ROBERT H. BLANK & ANDREA L. BONNICKSEN, *MEDICINE UNBOUND: THE HUMAN BODY AND THE LIMITS OF MEDICAL INTERVENTION* 216 (1994) (“[I]t would be legally dangerous for an institution to directly override an advance directive. This usually only occurs when a family is divided about how or when to apply it”). In one recent case, the physician complied with the patient’s mentally competent DNR order when the 78-year-old patient knew that he had a poor chance to survive from the surgery. Ann W. Latner, *Doctor Sued for Following Do Not Resuscitate Order*, RENAL & UROLOGY NEWS, Dec. 19, 2012, www.renalandurologynews.com/doctor-sued-for-following-a-do-not-resuscitate-order/article/273249/. But the patient’s son sued the physician for not following his (the son’s) instructions to perform CPR. *Id.* The logic is analogous to that of a robber shooting the convenience store clerk during a robbery. While murder is a more serious crime, it seems legally safer because it reduces the risk of enforcement.

¹⁵⁸ Amy Lynn Sorrel, *Litigation Stress: Being Sued Is Personal as Well as Professional*, AMERICAN MED. NEWS, Nov. 2, 2009, www.ama-assn.org/amednews/2009/11/02/prsa1102.htm; Catherine Kleghorn, *You’ve Been Served: Coping with the Stress of Medical Malpractice Litigation*, NORCAL MED. LIABILITY WATCH, Spring 2006, at 2; see also Waddell, *supra* note 157, at 812. “[O]n the other hand, a provider that acquiesces to the demands of a surrogate that a living will be overridden faces no liability risk . . .” *Id.*

¹⁵⁹ See, e.g., *Matter of Edna M.F.*, 563 N.W.2d 485 (Wis. 1997).

¹⁶⁰ Saitta & Hodge, *supra* note 52, at 232.

¹⁶¹ See *supra* Section III.B.3.

patient's surrogate decision maker because they doubt the surrogate's authority. Indeed, clinicians often have a legal duty to resist surrogates who exceed the scope of their authority.¹⁶²

Surrogates are agents of the patient (the principal). Accordingly, they must act in accordance with the patient's wishes or, where those are unknown, in accordance with the patient's best interests.¹⁶³ But substantial evidence shows that the choices surrogates make for patients are very often not the same choices that patients would make for themselves.¹⁶⁴ Surrogates often do not know patient preferences or best interests. And even when these are known, surrogates often fail to make consistent treatment decisions. Sometimes this is due to emotional and psychological barriers. Sometimes it is deliberate.¹⁶⁵ In short, clinicians may administer life-sustaining treatment over the objections of the patient's surrogate in certain circumstances.

7. *Uncertain Patient Decision-Making Capacity*

Most patients lack decision-making capacity at the time life-sustaining treatment is administered.¹⁶⁶ But some make a contemporaneous decision to refuse such treatment. Some of the most famous right-to-die cases in American jurisprudence have involved patients making their own treatment refusals: Elizabeth Bouvia,¹⁶⁷ Kenneth Bergstedt,¹⁶⁸ and Larry McAfee.¹⁶⁹

Clinicians might not honor contemporaneous decisions to refuse life-sustaining

¹⁶² See, e.g., *Cardoza v. U.S.C. Univ. Hosp.*, No. B195092, 2008 WL 3413312 (Cal. Ct. App. August 13, 2008); *Noval v. Kaiser Found. Health Plan*, No. RC-1201608 (Riverside Cty. Super. Ct., Cal. filed Feb. 2, 2012); *In re Tschumy*, No. 27-GC-PR-07-496 (Hennepin Cty. Dist. Ct., Minn. Oct. 18, 2012) (Order).

¹⁶³ See Pope, *supra* note 155.

¹⁶⁴ See Thaddeus M. Pope, *Legal Fundamentals of Surrogate Decision Making*, 141 CHEST 1074 (2012) (collecting studies).

¹⁶⁵ See, e.g., *Van Note Pleads Not Guilty to Father's Murder*, LAKE NEWS ONLINE, Sept. 10, 2012, <http://www.lakenewsonline.com/article/20120910/NEWS/120919835/1001/news> (reporting a grand jury indictment alleging that Susan Elizabeth Van Note forged her father's name to an advance directive to hasten his death so that she could inherit his estate).

¹⁶⁶ See generally A. Lautrette et al., *Surrogate Decision-Makers for Incompetent ICU Patients: A European Perspective*, 14 CURRENT OPINIONS CRITICAL CARE 714 (2008); S.M. Parks & L. Winter, *End-of-Life Decision-Making for Cancer Patients*, 36 PRIMARY CARE CLINICAL OFFICE PRACTICE 811 (2009).

¹⁶⁷ *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127 (Cal. Ct. App. 1986).

¹⁶⁸ *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990).

¹⁶⁹ *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989).

treatment because they doubt the capacity of the patient to make the decision.¹⁷⁰ Indeed, clinicians should not automatically comply with all patient refusals. An incapacitated refusal is no refusal at all.¹⁷¹ Acceding to an incapacitated patient's refusal does not protect or promote her autonomy. So, clinicians need some range of discretion.¹⁷²

But it must be carefully circumscribed, otherwise, clinician concerns about the adequacy of patient understanding could swallow the patient's right to refuse.¹⁷³ The clinician who disagrees with the patient's refusal may find the patient incapacitated and proceed to obtain consent from someone else.¹⁷⁴

8. *Inadequate Informed Consent*

Many patients actually do consent to continued life-sustaining treatment. But this hardly means that they "wanted" that treatment. Their consent is often misinformed or uninformed. Had the clinician adequately conveyed material information about the treatment, including alternatives and prognosis, then neither the patient nor a reasonable person in the patient's circumstances would have consented to the treatment. In short, the patient made a decision to accept treatment; there was no overriding of a refusal. Still, there is an overriding of the patient's autonomy. The patient's consent does not reflect her values and preferences, because it was not informed.¹⁷⁵

¹⁷⁰ Kenney F. Hegland, *Unauthorized Rendition of Lifesaving Medical Treatment*, 53 CALIF. L. REV. 860, 864 (1965) (arguing that "the law should require a high degree of certainty that he really desires to exercise this prerogative before giving it operative significance").

¹⁷¹ *State v. Escamea*, No. 2008AP1543-CR, 2009 WL 1586823 (Wis. App. 2009) (finding emergency room patient did not have capability to make refusal decision and was not aware of the risks and benefits).

¹⁷² Maria Aileen Soriano & Ruth Lagman, *When the Patient Says No*, 29 AM. J. HOSPICE & PALLIATIVE CARE 401, 402-03 (2012) ("The need to determine decisional capacity is greatest when refusal of treatment can result in death.").

¹⁷³ See Thaddeus M. Pope, *Is Public Health Paternalism Really Never Justified? A Response to Joel Feinberg*, 30 OKLA. CITY U. L. REV. 121 (2005) (criticizing Feinberg's soft paternalism as a solution to resolve liberty restrictions issues in the public health sector and suggesting to use hard paternalism instead).

¹⁷⁴ See, e.g., *Payne v. Marion Gen. Hosp.*, 549 N.E.2d 1043 (Ind. App. 1990); *Hendon v. William Beaumont Hosp.*, No. 176168 (Mich. App. May 28, 1996); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827 (W. Va. 1992).

¹⁷⁵ *Osgood v. Genesys Regional Med. Ctr.*, No. 94-26731-NH (Cir. Ct. Genesee Cty., Mich. 1996) (explaining a decision where a clinician did not adequately explain treatment procedures); Andrew Broder, *She Don't Want No Life Support*, 75 U. DET. MERCY L. REV. 595, 596 (1998);

This was the allegation in *Arato v. Avedon*.¹⁷⁶ When Miklos Arato was undergoing surgery to remove a diseased kidney, the operating surgeon detected a tumor on his pancreas.¹⁷⁷ Arato's oncologists recommended "F.A.M.," a treatment employing a combination of drugs which, when used in conjunction with radiation therapy, had shown promise in treating pancreatic cancer in experimental trials.¹⁷⁸ Arato consented to this course of treatment.¹⁷⁹ Unfortunately, the treatment proved ineffective.¹⁸⁰ Almost exactly one year after surgery, Arato succumbed to the effects of pancreatic cancer.¹⁸¹

The oncologists never disclosed to Arato the high statistical mortality rate associated with pancreatic cancer.¹⁸² It is an especially virulent malignancy in which only 5 to 10 percent of those afflicted live for as long as five years.¹⁸³ Therefore, given the practically incurable nature of the disease, there was little chance that Arato would live more than a short while, even if the proposed treatment proved effective.¹⁸⁴

In their subsequent lawsuit, Arato's family alleged that such mortality information was "material to Arato's decision whether to undergo postoperative treatment."¹⁸⁵ They argued that had Arato known the "bleak truth concerning his life expectancy, he would not have undergone the rigors of an unproven therapy."¹⁸⁶ Instead, he would have chosen to live out his last days at peace with his wife and children, and arrange his business affairs.¹⁸⁷

Arato is hardly an isolated case. The quality of informed consent regarding end-

Rauch, *supra* note 38 ("I think that's the most urgent issue facing America today, is people getting medical interventions that, if they were more informed, they would not want.") (quoting Angelo Volandes).

¹⁷⁶ *Arato v. Avedon*, 858 P.2d 598, 599 (Cal. 1993).

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *Arato*, 858 P.2d at 599-600.

¹⁸¹ *Id.*

¹⁸² *Id.* at 600.

¹⁸³ *Arato*, 858 P.2d at 602; see also *Pancreatic Cancer Survival Rates*, EMEDTV.COM, <http://cancer.emedtv.com/pancreatic-cancer/pancreatic-cancer-survival-rates.html> (last visited Apr. 30, 2013) (explaining pancreatic cancer survival rates between 1995-2001 were 4.6%).

¹⁸⁴ *Arato*, 858 P.2d at 602.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

of-life options is generally quite poor.¹⁸⁸ And the consequence is far more aggressive treatment than patients would prefer, if they understood the odds and alternatives.¹⁸⁹ Patients often do not know what options for palliative care and pain management are clinically and legally available to them at the end of life. Furthermore, patients may be hesitant to initiate conversations with their health care practitioners about certain end-of-life options. Consequently, patients are not empowered to control their health care decisions.

Both recognizing and responding to widespread reluctance to discuss end-of-life issues, several states have enacted “right to know” legislation.¹⁹⁰ These statutes mandate that if a health care provider makes a diagnosis that a patient has a terminal illness, then the health care provider, on the patient’s request, shall provide the patient with

¹⁸⁸ See Mirarchi et al., *supra* note 101, at 517 (reporting that physicians spend just 5.6 minutes discussing DNR and end-of-life issues with patients). “[A]ttorneys who create large numbers of advance directives do not have the medical scope of practice to inform the patient [about reversible and treatable conditions].” *Id.* In a 2012 survey, over 40% of physicians responded that they hide or might hide “information from a patient about a terminal or preterminal diagnosis.” *Physicians’ Top Ethical Dilemmas: Medscape 2012 Survey Results*, <http://www.medscape.com/features/slideshow/public/ethics2012>; see also Joan M. Teno et al., *Change in End-of-Life Care for Medicare Beneficiaries*, 309 JAMA 470 (2013); J.R. Curtis et al., *Missed Opportunities During Family Conferences about End-of-Life Care in the ICU*, 171 AM. J. RESPIRATORY & CRITICAL CARE MED. 855 (2005); J.E. Nelson et al., *When Critical Illness Becomes Chronic: Informational Needs of Patients and Families*, 20 J. CRITICAL CARE 79 (2005); E. Azoulay et al., *Half the Families of ICU Patients Experience Inadequate Communication with Physicians*, 28 CRITICAL CARE MED. 3044 (2000).

¹⁸⁹ MEISEL & CERMINARA, *supra* note 25, § 11.03[B][2]; see Jeffrey M. Peppercorn et al., *American Society of Clinical Oncology Statement: Toward Individualized Care for Patients With Advanced Cancer*, 29 J. CLINICAL ONCOLOGY 755, 755-56 (2011) (noting that despite improvements, conversations about palliative care often occur late in treatment). To address communication problems, states are requiring physicians to complete Continuing Medical Education (“CME”) on end-of-life issues. See, e.g., *State Medical Licensure Requirements and Statistics, 2012*, ACPONLINE, http://www.acponline.org/education_recertification/cme/state_requirements/2012ama_requirements.pdf. Facilities and professional associations are also providing more training. OncoTalk, for example, trains oncology fellows to communicate bad news, manage transitions to palliative care, and handle requests for futile therapies. ONCOTALK, <http://depts.washington.edu/oncotalk/> (last visited Apr. 30, 2013).

¹⁹⁰ See, e.g., CAL. HEALTH & SAFETY CODE § 442.5 (West Supp. 2013) (mandating information and counseling about end-of-life care upon request by terminally ill patient); MICH. COMP. LAWS ANN. § 333.5652 (West Supp. 2012) (raising awareness and encouraging better communication between patients and health care providers about terminal illness); N.Y. PUB. HEALTH L. § 2997-C (McKinney 2012 & Supp. 2013) (requiring practitioner of terminally ill patient to offer information and counseling about palliative care); VT. STAT. ANN. tit. 18, § 1871 (2012) (outlining patient’s bill of rights for palliative care and pain management).

comprehensive information and counseling regarding specified legal end-of-life care options.¹⁹¹

Another important informed consent development should also curb overtreatment. The development of patient decision aids is being incentivized at both the federal and state levels.¹⁹² Decision aids are educational “tools” that help patients understand the various treatment options available to them, including the risks and benefits of each choice. These tools include educational literature with graphics, photographs, and diagrams. They also take the form of videos and website-based interactive programs. Growing evidence demonstrates that decision aids improve patient knowledge and satisfaction. Moreover, patients using decision aids are more likely to choose conservative treatment options. They are less likely to choose surgical interventions. They are less likely to be admitted to the hospital. And they are less likely to choose CPR.¹⁹³

9. *Negligent Maintenance of Medical Records*

As discussed above, the unavailability of an advance directive is often the patient’s own fault. Either he or she never completed one or he or she never made it available to his or her surrogate or health care provider. But the unavailability of advance directives is also often the fault of health care providers.¹⁹⁴

For example, terminally ill Arthur Johnson signed forms instructing paramedics not to revive him if his heart stopped.¹⁹⁵ But when he was later transferred from

¹⁹¹ See CAL. HEALTH & SAFETY CODE § 442.5. The specified end-of-life care options typically include, but are not limited to: (1) the right to complete an advance directive; (2) hospice care at home or in a health care setting; (3) a prognosis with and without the continuation of disease-targeted treatment; (4) the right to refusal of or withdrawal from life-sustaining treatment; (5) the right to continue to pursue disease-targeted treatment, with or without concurrent palliative care; and (6) the right to comprehensive pain and symptom management at the end of life, including adequate pain medication, treatment of nausea, palliative chemotherapy, relief of shortness of breath and fatigue, and other clinical treatments useful when a patient is actively dying. *Id.*

¹⁹² Thaddeus M. Pope & Melinda Hexum, *Legal Briefing: Shared Decision Making and Patient Decision Aids*, 24 J. CLINICAL ETHICS 70-80 (2013).

¹⁹³ *Id.* (collecting studies); see also Angelo Volandes et al., *Randomized Controlled Study of a Video Support Tool for Cardiopulmonary Resuscitation Decision Making in Advanced Cancer*, 31 J. CLINICAL ONCOLOGY 380 (2013).

¹⁹⁴ See Bergman-Evans, *supra* note 57, at 350 (reporting 40% of respondents explained the advance directives were not followed because “[they] existed but were not on the chart[s]”).

¹⁹⁵ James Tozer, *Grandfather Dies in Agony Because Hospital Ignored Signed Declaration Stating He Didn't Want to Be Revived*, DAILY MAIL, June 9, 2010, available at

hospice to hospital, his DNR form was not passed on.¹⁹⁶ Accordingly, hospital staff tried to keep the 64-year-old grandfather alive against his wishes, leaving him to spend the final three hours of his life in pain.¹⁹⁷

Advance directives and other instructions are frequently not placed into the medical record.¹⁹⁸ Many facilities tried to address this problem through the use of colored wristbands.¹⁹⁹ But they soon discovered that different facilities in the same areas were using up to nine different colors to signify DNR.²⁰⁰

10. *Vitalistic Philosophy of Medicine*

While law and ethics strongly support patient autonomy and self-determination, there remains a significant amount of physician paternalism. This is colorfully illustrated

<http://www.dailymail.co.uk/news/article-1285363/Grandfather-dies-agony-hospital-ignored-signed-declaration-stating-didnt-want-revived.html>.

¹⁹⁶ *Id.* See also *Hallada v. Lakeland Reg. Med. Ctr.*, No. 2103CA-002054 (Polk Cty. Cir. Ct., Fla. Apr. 1, 2013) (Complaint filed) (alleging that DNR order was not transferred from hospital to nursing home).

¹⁹⁷ *Id.*

¹⁹⁸ See Angela Fagerlin & Carl E. Schneider, *Enough: The Failure of the Living Will*, 34 HASTINGS CTR. REP., Mar.-Apr. 2004, at 35 (finding only 26% of patient charts accurately recorded information about the patient's directive); Joan M. Teno et al., *Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self Determination Act and the SUPPORT Intervention*, 45 J. AM. GERIATRICS SOC'Y 500, 507 (1997) (stating only one in three advance directives is placed in medical records); J. Virmani et al., *Relationship of Advance Directives to Physician-Patient Communication*, 154 ARCHIVES INTERNAL MED. 909, 912 (1994) (stating 41% of patients believed their doctor would know what to do in an end of life situation); CHARLES P. SABATINO, A.B.A. COMM'N ON L. & AGING, *ADVANCE DIRECTIVES AND ADVANCE CARE PLANNING: LEGAL AND POLICY ISSUES* 19 (2007) (identifying lack of provider knowledge regarding patients' directives as part of difficulty with advance directives); Dembner, *supra* note 39 ("Do-not-resuscitate orders are misplaced or overlooked in the hospital, or are not available at all because they are on record somewhere else."); Daren K. Heyland et al., *Failure to Engage Hospitalized Elderly Patients and Their Families in Advance Care Planning*, JAMA INTERN MED., Apr. 2013, at 1-10 (E-publication ahead of print) (finding six times as many patients wanted comfort measures only as had that documented in their medical records).

¹⁹⁹ See, e.g., TEXAS HOSP.L ASS'N, *COLOR-CODED WRISTBAND STANDARDIZATION PROJECT IN TEXAS* 2 (2008), available at http://www.tha.org/HealthCareProviders/Issues/PatientSafetyQuality/Wristband/TX%20Wristband%20Toolkit_Color.pdf.

²⁰⁰ *Id.* State medical associations have made substantial progress toward making wristband use more consistent and uniform. See *id.* (noting by fall 2008 over 25 states had implemented hospital wristband use for select purposes). The use of POLST has also improved the clarity and transportability of medical records. Susan E. Hickman et al., *The POLST (Physicians Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care*, 36 J.L. MED. & ETHICS 119, 119 (2008).

by Dr. Yoonessi's arrogant and reckless disregard for his patient's rights.²⁰¹ Dr. Yoonessi thought it was wrong to forgo therapeutic interventions no matter how limited the benefit, no matter how long the odds, and no matter how severe the side effects.²⁰²

Many physicians are not ready to "give up." In general, many physicians still consider it "their responsibility to make treatment decisions that they believe are in the patient's best interest and that patient preferences should be ignored if they are inconsistent with the physician's view of the patient's best interests."²⁰³ Even when physicians know a patient's preference, they may disregard it as "not in the patient's best interests."²⁰⁴

11. Conscience-Based Objection

Clinicians may object to complying with patient wishes not only on professional or paternalistic grounds, but also on personal grounds. For example, "a healthcare provider may have a powerful personal moral bias that all life is worth saving and that everything possible should be done for every patient."²⁰⁵ Accordingly, that provider may intentionally ignore the patient's instructions.

Nearly all states grant clinicians the right of refusal based on conscience or

²⁰¹ See *supra* notes 1-9 and accompanying text; see *infra* notes 482-502 and accompanying text.

²⁰² See *supra* notes 7-9 and accompanying text.

²⁰³ David Orentlicher, *The Limits of Legislation*, 53 MD. L. REV. 1255, 1281 (1994); see Burkle et al., *supra* note 70, at 7 (finding 15% of physicians agreed they should be allowed to provide care notwithstanding advance directives). "Physicians should be allowed to provide care independent of the advance directive as patients do not have the knowledge to best appreciate the idiosyncrasies involved with the practice of medicine." *Id.*; see also Nicholas A. Christakis & David A. Asch, *Medical Specialists Prefer to Withdraw Familiar Technologies when Discontinuing Life Support*, 10 J. GEN. INTERNAL MED. 491, 491 (1995) (reporting specialty physician preference for withdrawing their "own" form of life support over other specialties); Graeme M. Rocker & J. Randall Curtis, *Caring for the Dying in the Intensive Care Unit: In Search of Clarity*, 290 JAMA 820, 821 (2003) ("Physician biases influence willingness to withhold or withdraw life support."); Dembner, *supra* note 39 (statement of Dr. David Clive) ("There's still a fair number of doctors around who are uncomfortable with patients being DNR . . . [It may be the physician's] medical opinion that the patient is not sufficiently ill to warrant the DNR order.").

²⁰⁴ Bernard Lo, *Improving Care Near the End of Life: Why Is It So Hard?*, 274 JAMA 1634, 1635 (1995); see also Bernard Lo & Robert Steinbrook, *Resuscitating Advance Directives*, 164 ARCHIVES INTERNAL MED. 1501, 1502 (2004) (concluding that advance directives "frequently have little impact on clinical decisions").

²⁰⁵ Saitta & Hodge, *supra* note 52, at 231 (quoting E-Mail from Jack E. Hubbard, Ph.D., M.D., Doctor of Adult Neurology, Minneapolis Clinic of Neurology (June 24, 2011)).

other moral objections.²⁰⁶ Most of these states have entirely open-ended criteria that permit providers to decline to comply with patients' wishes for any reason. Protecting the moral values of clinicians is important.²⁰⁷ But some have observed that the scope of conscience clauses "may give clinicians license to ignore patients' wishes."²⁰⁸

12. Financial Incentives

A final reason that clinicians administer unwanted life-sustaining treatment is that overtreatment is well-reimbursed.²⁰⁹ Clinicians are often "paid more for doing more."²¹⁰ One very visible manifestation of this financial incentive is massive and still-growing fraud and abuse enforcement.²¹¹ Health care providers are routinely charged with fraudulently administering unwanted treatment in order to maximize revenues.²¹²

At one extreme, hospitals have been accused of "extend[ing] hospitalization through assigning release dates designed only to coincide with the expiration of insurance benefits" rather than "on the basis of the patient's condition."²¹³ But even at

²⁰⁶ See Thaddeus M. Pope, *Legal Briefing: Conscience Clauses and Conscientious Refusal*, 21 J. CLINICAL ETHICS 163 (2010) [hereinafter *Conscience Clauses*]; Castillo et al., *supra* note 68, at Appendix, Table 3 (excepting Indiana and Michigan from states that have provider right of refusal statutes).

²⁰⁷ The author is a legal consultant to a committee of the American Thoracic Society that is drafting a policy statement tentatively titled "Managing Conscientious Objection in Intensive Care Medicine."

²⁰⁸ Castillo et al., *supra* note 68, at 124; see also Elizabeth Sepper, *Not Only the Doctor's Dilemma: The Complexity of Conscience in Medicine*, FAULKNER L. REV. (forthcoming 2013); Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501 (2012).

²⁰⁹ Peter J. Kalis & Judy Hlafcsak, *Healthcare Reform: Let's Act Locally*, 50 DUQ. L. REV. 253, 258 (2012) (noting "our [medical] payment system rewards medical utilization . . ."); S. Elizabeth Wilborn, *The Right to Refuse Medical Treatment: Where There is a Right, There Ought to be a Remedy*, 25 N. KY. L. REV. 649, 658 (1998); Sunil Eappen et al., *Relationship Between Occurrence of Surgical Complications and Hospital Finances*, 309 JAMA 1599 (2013) (finding that hospitals have little incentive to reduce surgical errors because they get paid for longer stays and extra care that patients require for the resulting complications).

²¹⁰ David Orentlicher, *Cost Containment and the Patient Protection and Affordable Care Act*, 6 FIU L. REV. 67, 71 (2010); Lars Noah, *Turn the Beat Around: Deactivating Implanted Cardiac-Assist Devices*, 39 WM. MITCHELL L. REV. 1229, 1231-36 (2013).

²¹¹ See, e.g., T. R. Goldman, *Eliminating Fraud and Abuse*, HEALTH AFFAIRS HEALTH POL'Y BRIEF (July 31, 2012).

²¹² See, e.g., *60 Minutes: Hospitals: The Cost of Admission* (CBS television broadcast Dec. 2, 2012), available at <http://www.cbsnews.com/video/watch/?id=50136261n>; Reed Abelson, *U.S. Settles Accusations That Doctors Overtreated*, N.Y. TIMES, Jan. 4, 2013; *U.S. v. Vitas Hospice Care, Inc.*, No. 3:07-CV-00604-M (N.D. Tex. Sept. 29, 2009) (complaint alleging hospice kept treating patients even when they were no longer qualified).

²¹³ *Paulk v. Nat'l Med. Enters.*, 679 So. 2d 1289, 1291 (Fla. App. 1996) (Stone, J., dissenting). On

a less nefarious level, physicians “will continue to allocate their time to activities that generate higher compensation.”²¹⁴ The current fee-for-service reimbursement model incentivizes clinicians to provide more treatment and to deploy more technology, even more than the patient desires.²¹⁵

13. Summary

In sum, there are many factors, working both independently and inter-dependently, that cause clinicians to administer unwanted life-sustaining treatment. Facilitating the operation and impact of these factors is the clinician’s belief that administering unwanted life-sustaining treatment entails little legal risk.²¹⁶

IV. Clinicians Think that Providing Life-Sustaining Treatment without Consent Entails Little Legal Risk

“The general view from the medical front . . . is that you can’t be sued for doing too much, you can only be sued for doing too little.”²¹⁷ Indeed, a 2012 survey found

the other hand, other lawsuits allege that providers’ financial incentives cause them to provide less, not more, treatment. *See, e.g., Yarick v. Pacificare of Cal.*, 179 Cal. App. 4th 1158, 1162 (Cal. App. 2009). Slowly, financial incentives are being more aligned and correlated to quality outcomes. *See, e.g.,* Dep’t Health & Human Services, *Medicare Program; Hospital Inpatient Value-Based Purchasing Program*, 76 Fed. Reg. 2454 (Jan. 13, 2011); David Eggert, *Insurer, Mich. Hospitals Switch Reimbursement Plan*, S.F. CHRON., Apr. 30, 2013, <http://www.sfgate.com/news/article/Insurer-Mich-hospitals-switch-reimbursement-plan-4472545.php>.

²¹⁴ Orentlicher, *supra* note 203, at 1275-76.

²¹⁵ *See, e.g.,* John D. Lantos, *Hooked on Neonatology: A Pediatrician Wonders about NICUs’ Hidden Cost of Success*, 20 HEALTH AFFAIRS 233, 237 (2001); Ronen Avraham, *Clinical Practice Guidelines - The Warped Incentives in the U.S. Healthcare System*, 37 AM. J. L. & MED. 7, 8-9 (2011) (discussing “offensive medicine”). Only 17% of physicians think “the financial cost of providing medical care should . . . impact a decision to honor or forgo expressed wishes noted in an [advance directive].” Burkle et al., *supra* note 70, at Table 5; *see also* Massachusetts Expert Panel on End-of-Life Care, *Patient Centered Care and Human Mortality: The Urgency of Health System Reforms to Ensure Respect for Patients’ Wishes and Accountability for Excellence in Care*, <http://mass.gov.healthcare/expertpanel>.

²¹⁶ If the threat of sanctions appeared more imminent or serious, clinicians would work harder to mitigate some of these factors. But “the media encourages doctors to practice defensive medicine by publishing stories about patients with obscure presentations of diseases who die because doctors ‘just didn’t do enough.’” BirdStrike, *Cause of Death: Defensive Medicine*, KEVINMD (Oct. 5, 2012), <http://www.kevinmd.com/blog/2012/10/death-defensive-medicine.html>.

²¹⁷ *When Is Medical Treatment Futile?*, ABC RADIO NATIONAL (Nov. 5, 2012) (quoting Dr. Peter Saul), *available at*

<http://www.abc.net.au/radionational/programs/healthreport/when-is-medical-treatment-futile3f/4349592>.

See also Stephen Wear et al., *Toleration of Moral Diversity and the Conscientious*

that a majority of physicians agree that there is less liability risk for “maintaining someone alive against their will than mistakenly allowing them to die.”²¹⁸ The thinking among clinicians has been that if “you do intervene and you shouldn’t have, the worst that will happen is that the patient will live a little longer and that you’ll never be held accountable if you keep the patient from dying.”²¹⁹ Clinicians find it “counterintuitive” to be “held accountable for preserving the life of a patient.”²²⁰

And clinicians are not the only ones to reach this conclusion. Attorneys often advise health care institutions and physicians to “play it safe” when in doubt and just administer treatment.²²¹ This advice seems consistent with the literature. Legal commentators have generally agreed that “there are few, if any, effective incentives for physicians and other healthcare providers to be scrupulous in their adherence to advance directives.”²²² “[N]either judges nor lawmakers have yet formulated coherent or effective remedies for physicians’ failures to comply with the instructions patients have provided.”²²³

Other legal commentators have similarly concluded that the right to refuse life-sustaining treatment is “illusory,” because there is no effective remedy.²²⁴ They observe

Refusal by Physicians to Withdraw Life-Sustaining Treatment, 19 J. MED. & PHIL. 147, 153 (1994) (“Many physicians seem to believe that an active withdrawal involves significantly more legal jeopardy than a passive withdrawal . . .”). There is some basis for thinking that there is more legal risk from taking no action. Bryan A. Liang & Justin A. Zivin, *Empirical Characteristics of Litigation Involving Tissue Plasminogen Activator and Ischemic Stroke*, 52 ANNALS EMERGENCY MED. 160 (2008). For example, in the emergency context, one study found 29 of 33 cases alleged failure to treat with tPA but only 3 alleged injury from the administration of tPA. *Id.*; see also David E. Thiess et al., *Hot Topics in Risk Management in Neurologic Practice*, 28 NEUROLOGY CLINICS 429, 431 (2010).

²¹⁸ Burkle et al., *supra* note 70, at 7.

²¹⁹ Tamar Lewin, *Ignoring ‘Right to Die’ Directives, Medical Community Is Being Sued*, N.Y. TIMES, June 2, 1996, at A1 (quoting Nancy Dickey).

²²⁰ CHRISTOPHER DANBURY ET AL., LAW AND ETHICS IN INTENSIVE CARE 125-26 (2010).

²²¹ MEISEL & CERMINARA, *supra* note 25 at § 11.01[A].

²²² Lynch et al., *supra* note 37, at 138.

²²³ Lynch et al., *supra* note 37, at 138; see also *id.* at 139 (noting “the current legal framework offers little support for recovery”); *id.* at 147 (observing “cases in which damages have been awarded . . . have been few and far between”); *id.* at 148 (cautioning “optimists should be extremely cautious”); *id.* at 177 (declaring “The current legal structure has proven impotent to resolve this problem.”); see also Maggie J. Randall Robb, *Living Wills: The Right to Refuse Life Sustaining Medical Treatment—A Right Without a Remedy?*, 23 U. DAYTON L. REV. 169 (1997); S. Elizabeth Wilborn, *The Right to Refuse Medical Treatment: Where There Is a Right, There Ought to Be a Remedy*, 25 N. KY. L. REV. 649 (1998).

²²⁴ Channick, *supra* note 54, at 619-20; see also Donohue, *supra* note 11, at 394 (concluding that

that “very few health care professionals or institutions have been held liable for damages for administering . . . life-sustaining treatment without authorization. . . .”²²⁵ Others have similarly concluded that “there is no effective penalty for disregarding a living will.”²²⁶ “[N]o recognized cause of action has really emerged allowing for the awarding of monetary damages. . . . Recovering . . . damages is not a realistic option at the present time.”²²⁷

Reviewing this literature, a 2011 Resolution to the American Bar Association House of Delegates concluded that the law “does not adequately protect patients from unwanted treatment,” because “the threat of lawsuit does not adequately deter unwanted treatment.”²²⁸

There are three main reasons that medical and legal commentators have concluded that there is little legal risk in administering life-sustaining treatment without consent. First, clinicians can often obtain *ex ante* injunctions and guardianships, judicially authorizing treatment over patient or surrogate objections. Second, even when overriding patient refusals without prior judicial permission, sanctions appear unlikely because of the salience of unsuccessful *ex post* cases for damages. Third, these unsuccessful cases have highlighted four formidable hurdles to establishing liability.

A. Clinicians Can Often Obtain Ex Ante Injunctions and Guardianships

Clinicians bear no risk for administering unwanted treatment, if they get permission to do so. Treatment can be simultaneously consensual and unwanted, because the clinician obtains permission from someone other than the patient.

Procedurally, there are three means by which a clinician can achieve this. First, the clinician can seek the court appointment of a guardian, and then get consent from

patients “have encountered significant difficulty in realizing damages for these claims”).

²²⁵ MEISEL & CERMINARA, *supra* note 25, at § 11.11.

²²⁶ Waddell, *supra* note 157, at 818.

²²⁷ Saitta & Hodge, *supra* note 52, at 238. A handful of commentators have been more optimistic. See, e.g., Renee Martin, *Liability for Failing to Follow Advance Directives*, PHYSICIAN'S NEWS DIGEST (Sept. 1999), <http://www.physiciansnews.com/1999/09/14/liability-for-failing-to-follow-advance-directives/> (“[C]ivil liability for failure to respect end-of-life decisions may grow.”); Rodriguez, *supra* note 11; William H. Pedrick, *Dignified Death and the Law of Torts*, 28 SAN DIEGO L. REV. 387 (1991); William H. Pedrick, *Arizona Tort Law and Dignified Death*, 22 ARIZ. ST. L. REV. 63 (1990).

²²⁸ A.B.A., COMM'N ON L. & AGING, REPORT TO THE HOUSE OF DELEGATES, RESOLUTION 106B, at 6 (2011).

the guardian.²²⁹ Second, the clinician can seek an injunction granting permission to administer the treatment.²³⁰ Third, in some states, the clinician can select the surrogate without any court involvement whatsoever.²³¹

For example, in *In re Duran*, Maria Duran needed a liver transplant.²³² Since she was a Jehovah's Witness, she went to the University of Pittsburgh Medical Center, because she had been told that it had performed liver transplants without blood transfusions.²³³ Ms. Duran discussed her religious beliefs and her desire to not be given any blood products or transfusions.²³⁴ She also executed an advance directive, specifically stating that she would refuse any blood, no matter what her medical condition.²³⁵

Unfortunately, Ms. Duran's body rejected the liver as well as a second liver transplant.²³⁶ Ms. Duran was comatose and her condition was worsening.²³⁷ Clinicians thought that she would die within 24 hours if she were not given a transfusion.²³⁸ So, Ms. Duran's husband petitioned the court to be appointed her "emergency limited

²²⁹ See, e.g., *In re Estate of Dorone*, 534 A.2d 452, 455 (Pa. 1987) (affirming trial court's appointment of hospital administrator to consent to blood transfusions on behalf of adult Jehovah's Witness); *In re Lydia A. Hall Hosp.*, 459 N.Y.S.2d 682, 682 (N.Y. Sup. 1982) (discussing hospital's attempt to seek authorization to continue hemodialysis treatment). Cf. Pope, *Surrogate Selection*, *supra* note 164 (collecting cases where clinicians replaced surrogates who refused to consent to the proposed treatment plan).

²³⁰ See, e.g., several cases from the Consent and Capacity Board of Ontario, including: BT, 2011 CanLII 20996 (ON C.C.B.) (Can.), available at <http://www.canlii.org/en/on/oncccb/doc/2011/2011canlii20996/2011canlii20996.html>; BT, 2011 CanLII 20996 (ON C.C.B.) (Can.), available at <http://www.canlii.org/en/on/oncccb/doc/2011/2011canlii20996/2011canlii20996.html>; LF, 2010 CanLII 56501 (ON C.C.B.) (Can.), available at <http://www.canlii.org/en/on/oncccb/doc/2010/2010canlii56501/2010canlii56501.html>. While providers obtain injunctions authorizing treatment, patients are also able to obtain injunctions ordering clinicians to comply with their refusals. See Kathleen E. Wherthey, *Causes of Action to Recover Damages for Health Care Provider's Failure to Comply with Advance Directive*, in 16 CAUSES OF ACTION 2D 83, § 2 (2012) (collecting authority). Indeed, one court relied on the availability of *ex ante* relief as a reason to deny *ex post* relief. *Duarte v. Chino Comm. Hosp.*, 85 Cal. Rptr. 2d 521, 526 (Cal. Ct. App. 1999).

²³¹ See, e.g., TENN. CODE ANN. § 68-11-1806(c)(1) (2004).

²³² 769 A.2d 497, 500 (Pa. Super. Ct. 2001).

²³³ *Id.*

²³⁴ *Id.*

²³⁵ *Id.*

²³⁶ *Id.* at 501.

²³⁷ *Id.*

²³⁸ *Duran*, 769 A.2d at 501.

guardian for the purpose of consenting to a blood transfusion.²³⁹ The court granted Mr. Duran's petition.²⁴⁰ He then consented to the transfusion.²⁴¹

Health care providers sometimes seek, and obtain, third-party consent to override what they consider to be a foolish decision by the patient or surrogate. But they might also seek third-party consent because they are unsure whether the surrogate has the authority to refuse treatment on the patient's behalf.²⁴² Providers invariably continue administering the rejected treatment during the pendency of the proceedings.

B. Salience of Unsuccessful Ex Post Cases

A second reason that clinicians think administering life-sustaining treatment without consent entails little legal risk is because of the salience of several unsuccessful cases for damages.²⁴³ These unsuccessful cases are prominent in clinicians' perceptions relative to other cases. Consistent with now well-accepted principles of behavioral economics such as the availability heuristic, clinicians tend to overemphasize these cases and consequently overweigh the probability that future cases will have a similar result.²⁴⁴ This is the same psychological phenomenon that causes travelers to overestimate the risks of plane crashes relative to the much higher risk of an automobile crash.²⁴⁵

This exaggeration of the impact of unsuccessful cases is well-illustrated by *Miller v. HCA*.²⁴⁶ In August 1990, Karla Miller went into premature labor at 23 weeks gestation.²⁴⁷ Clinicians told the Millers that their baby would not survive without assistance and that there was a high probability their baby would suffer from severe and

²³⁹ *Id.*

²⁴⁰ *Id.*

²⁴¹ *Id.* Ms. Duran's health care agent appealed this order. *Id.* at 500. The appellate court held that the trial court abrogated Ms. Duran's right when it appointed the emergency limited guardian. *Id.* at 508.

²⁴² *Grace Plaza of Great Neck v. Elbaum*, 588 N.Y.S.2d 853, 855 (N.Y. App. Div. 1992).

²⁴³ Mark Strasser, *A Jurisprudence in Disarray: On Battery, Wrongful Living, and the Right of Bodily Integrity*, 36 SAN DIEGO L. REV. 997, 998 (1999); see, e.g., *HCA, Inc. v. Miller*, 36 S.W.3d 187, 189 (Tex. App. 2000), *aff'd*, 118 S.W.3d 758 (Tex. 2003) (holding hospital not liable in tort for resuscitating patient without consent).

²⁴⁴ See generally Cass R. Sunstein, *Empirically Informed Regulation*, 78 U. CHI. L. REV. 1349, 1354-55, 1405-07 (2011); Christine Jolls et al., *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471 (1998).

²⁴⁵ DANIEL KAHNEMAN, *THINKING, FAST AND SLOW* 109-98, 300-33 (2011).

²⁴⁶ *HCA, Inc.*, 36 S.W.3d at 189-97.

²⁴⁷ *Id.* at 190.

permanent disabilities.²⁴⁸ The Millers instructed that clinicians not resuscitate their infant or take any extraordinary measures to keep her alive.²⁴⁹ But the hospital administration determined that if the baby was born alive and weighed more than 500 grams, it would be resuscitated.²⁵⁰ Sidney Miller was born alive.²⁵¹ And consistent with the hospital policy, but contrary to her parents' instructions, the hospital resuscitated Sidney.²⁵² Today, she is profoundly mentally retarded, has cerebral palsy, cannot see, cannot walk, cannot talk, and cannot feed herself.²⁵³

Two years after Sidney's birth, the Millers sued the hospital and its parent corporation, Hospital Corporation of America ("HCA"), alleging battery and negligence. After a trial in 1997, a jury found that the HCA had acted without consent and awarded the Millers \$60 million (\$29.4 million in actual damages for medical expenses, \$17.5 million in prejudgment interest, and \$13.5 million in exemplary damages).²⁵⁴

Three years later, this verdict was reversed by the Texas Supreme Court.²⁵⁵ The court held that a physician confronted with an emergency situation may provide life-saving treatment without first obtaining parental consent.²⁵⁶ The ruling was extensively covered by medical journals and newsletters, giving it significant conspicuousness and prominence.²⁵⁷

Like the Texas Supreme Court's holding in *Miller*, in *Stewart-Graves v. Vaughn*, the

²⁴⁸ *Id.*

²⁴⁹ *Id.*

²⁵⁰ *Id.*

²⁵¹ *Id.*

²⁵² *HCA, Inc.*, 36 S.W.3d at 190.

²⁵³ *Id.*

²⁵⁴ *Id.* at 187.

²⁵⁵ *HCA, Inc. v. Miller*, 118 S.W.3d 758, 762 (Tex. 2003).

²⁵⁶ *Id.* at 761; see *Nelson v. Krusen*, 678 S.W.2d 918, 925 (Tex. 1984) (holding wrongful life cause of action "impossible to rationally decide whether the plaintiff has been damaged at all").

²⁵⁷ See, e.g., Andis Robeznieks, *Texas Court Dismisses Battery Charge in Resuscitation Case*, AM. MED. NEWS (Nov. 10, 2003); George J. Annas, *Extremely Preterm Birth and Parental Authority to Refuse Treatment--The Case of Sidney Miller*, 351 NEW ENG. J. MED. 2118 (2004), available at <http://www.nejm.org/doi/full/10.1056/NEJMLim041201>; John J. Paris, *Resuscitation Decisions for "Fetal Infants"*, 115 PEDIATRICS 1415 (2005); J.C. West, *Parents Do Not Have Authority to Refuse to Consent to Resuscitation of Fetus Born Alive*, 21 J. HEALTHCARE RISK MANAGEMENT 33 (2001), available at <http://onlinelibrary.wiley.com/doi/10.1002/jhrm.5600210308/pdf>. The intermediate appellate court's reversal, on other grounds, was also covered by the medical press. See, e.g., Vida Foubister, *Texas Court Overturns Ruling on Resuscitation of Premature Baby*, AM. MED. NEWS, Feb. 5, 2001.

Washington Supreme Court similarly held that a physician's continued resuscitation of a newborn child after 15 minutes of asystole came within the medical emergency exception to informed consent.²⁵⁸

In *Stewart-Graves*, the neonatologist was confronted with an emergency circumstance following the delivery of a severely premature infant.²⁵⁹ Despite the parents' pre-delivery refusal of consent to life-sustaining treatment, the court held that the hospital was not required to seek court intervention before providing life-sustaining treatment without committing battery.²⁶⁰ The neonatologist could not make an informed assessment of the infant's condition until after a live birth.²⁶¹ The infant was born alive, but in distress.²⁶² Consequently, there was no time for the hospital to obtain court intervention to override the parents' refusal of consent without jeopardizing the infant's life.²⁶³

One final case amply exemplifies how the salience and conspicuousness of unsuccessful lawsuits fosters a perception that administering unwanted life-sustaining treatment entails little legal risk. In *Grace Plaza of Great Neck v. Elbaum*, the nursing home refused to follow instructions of the patient's spouse to remove the feeding tube.²⁶⁴ Not only was the spouse unable to sue for damages, but the court even allowed the nursing home to recover payment for the treatment.²⁶⁵ The spouse was financially responsible for treatment that he had specifically and vehemently rejected.²⁶⁶

²⁵⁸ *Stewart-Graves v. Vaughn*, 170 P.3d 1151, 1158 (Wash. 2007); see also *Branom v. State*, 974 P.2d 335, 338 (Wash. 1999) (holding no cause of action against neonatologist's care of severely neurologically impaired infant son); *Glasner v. Howick*, No. 03A01-9612-CV-00401, 1997 WL 677955, at *1 (Tenn. Ct. App. 1997) (ruling for defendants where newborn was successfully resuscitated against parents' wishes).

²⁵⁹ *Stewart-Graves*, 170 P.3d at 1154.

²⁶⁰ *Id.* at 1155.

²⁶¹ *Id.* at 1154; see *HCA, Inc.*, 118 S.W.3d at 762 (testifying physician stated "that to deny any attempts at resuscitation without seeing the infant's condition would be inappropriate and below the standard of care").

²⁶² *Stewart-Graves*, 170 P.3d at 1154. The infant, being born without a heart rate and spontaneous respiration, and with an Apgar score of zero, caused a code team to perform resuscitative efforts for twenty-four minutes until a spontaneous heart rate occurred in the newborn. *Id.*

²⁶³ *Id.* at 1152. Disagreeing physicians may seek judicial intervention when confronted with a decision to withdraw or withhold life-sustaining treatment, but have more immediate discretion when in an emergency due to the gravity of the situation. *Id.*

²⁶⁴ *Grace Plaza v. Elbaum*, 623 N.E.2d 513, 514 (N.Y. 1993).

²⁶⁵ *Id.* at 516; see also George J. Annas, *Adding Injustice to Injury — Compulsory Payment for Unwanted Treatment*, 327 NEW ENG. J. MED. 1885 (1992).

²⁶⁶ *Grace Plaza*, 623 N.E.2d at 516.

C. Legal Obstacles to Liability

In addition to both the availability of *ex ante* permission and the salience of unsuccessful *ex post* cases for damages, clinicians think that administering unwanted treatment entails little legal risk, because of five prominent obstacles to establishing liability: (1) rejection of the “wrongful living” cause of action; (2) rejection of private claims under the PSDA; (3) the emergency exception to informed consent; (4) safe harbor legal immunity under healthcare decisions acts; and (5) conscience clauses.²⁶⁷

1. Rejection of “Wrongful Living” Cause of Action

Related to the salience of unsuccessful damages cases in general is the salience of the nearly universal rejection of a legal theory for “wrongful living” or “wrongful prolongation of life.”²⁶⁸ The essence of this theory is that the claimed loss is the prolongation of life itself.

It is useful to place the “wrongful living” theory in context. There are several related causes of action.²⁶⁹ First, “wrongful pregnancy” or “wrongful conception” asserts the negligence of the clinicians pertaining to the performance of the sterilization procedure.²⁷⁰ Second, “wrongful birth” is where the negligence of the clinician pertains to the failure to diagnose a genetic defect. Had it been diagnosed the parents might have either avoided conception or would not have continued the pregnancy.²⁷¹ Third, “wrongful life” is where the child maintains an action that is the equivalent of the

²⁶⁷ There are, of course, other legal obstacles. I focus here on those most reinforcing the perception that administering unwanted, life-sustaining treatment entails little legal risk. Other legal obstacles are far more formidable. For example, because of their reduced liberty, prisoners often lose refusal of treatment cases. *See, e.g.,* *Brown v. Hume*, No. CIV S-11-3441, 2012 U.S. Dist. LEXIS 53382, at *1 (E.D. Cal. 2012); *Sama v. Hannigan*, 669 F.3d 585, 596 (5th Cir. 2012); *Lackey v. Hayes*, No. CV 112-069, 2012 U.S. Dist. LEXIS 153608, at *1 (S.D. Ga. 2012); *Commonwealth v. Kallinger*, 580 A.2d 887, 889 (Pa. Commw. Ct. 1990); *see also* *Runnels v. Rosendale*, 499 F.2d 733, 737 (9th Cir. 1974) (overruling lower court in favor of inmate’s claim of lack of consent for hemorrhoidectomy).

²⁶⁸ KATHLEEN E. WHERTHEY, 16 CAUSES OF ACTION 2D 83, at § 10 (2001) (“[T]his theory is largely experimental and courts generally have not been hospitable to it”).

²⁶⁹ *See* *Smith v. Gore*, 728 S.W.2d 738, 741 (Tenn. 1987) (listing three causes of action in the wrongful living context).

²⁷⁰ *Cowe v. Forum Group, Inc.*, 575 N.E.2d 630, 633 (Ind. 1991); *Johnson v. Univ. Hosp. of Cleveland*, 540 N.E.2d 1370, 1372 (Ohio 1989).

²⁷¹ *See* *Johnson*, 540 N.E.2d at 1372; *Harbeson v. Parke-Davis, Inc.*, 656 P.2d 483, 487 (Wash. 1983).

parent's wrongful birth action.²⁷² Most jurisdictions allow wrongful birth, but not wrongful life.²⁷³

Similarly, most jurisdictions that have confronted the question have rejected "wrongful living" and "prolongation of life" as a distinct cause of action. Most famously, the theory has been repeatedly rejected by the Ohio Supreme Court.²⁷⁴ But "wrongful living" has also been rejected by appellate courts in Indiana,²⁷⁵ New Jersey,²⁷⁶ Washington,²⁷⁷ and other states.²⁷⁸

These courts have rested the basis for their rejection on one or both of two reasons. First, the courts concluded that continued life is necessarily a benefit, not harm.²⁷⁹ One cannot, therefore, have a cause of action premised on the prolongation of life as the claimed "injury."²⁸⁰ Second, even if wrongful prolongation were a legally cognizable injury, it is incapable of quantification.²⁸¹ Life itself is not a compensable damage.²⁸²

"Wrongful living" seems to neatly capture the essence of the nonconsensual administration of life-sustaining treatment. Therefore, its rejection seems tantamount to rejection of any legal remedy regarding the right to refuse treatment.²⁸³

²⁷² *Stewart-Graves v. Vaighn*, 170 P.3d 1151, 1160 (Wash. 2007).

²⁷³ *Milani*, *infra* note 362, at 194-95.

²⁷⁴ *See, e.g., Anderson v. St. Francis-St. George Hosp., Inc.*, 671 N.E. 2d 225, 227-29; *Allore v. Flower Hosp.*, 699 N.E.2d 560, 565 (Ohio Ct. App. 1997).

²⁷⁵ *Taylor v. Muncie Med. Investors*, 727 N.E.2d 466, 471 (Ind. Ct. App. 2000) (rejecting claim for "wrongful prolongation of life").

²⁷⁶ *McGuinness v. Barnes*, No. A-3457-94T5, slip op. at 8-9 (N.J. Super. Ct. App. Div. Aug. 6, 1996).

²⁷⁷ *Benoy v. Simons*, 831 P.2d 167, 170 (Wash. Ct. App. 1992).

²⁷⁸ *See, e.g., Greco v. U.S.*, 893 P.2d 345, 347-48 (Nev. 1995); *Lininger v. Eisenbaum*, 764 P.2d 1202, 1212 (Colo. 1988).

²⁷⁹ *See, e.g., Greco*, 893 P.2d at 348; *Lininger*, 764 P.2d at 1210.

²⁸⁰ *See, e.g., Greco*, 893 P.2d at 347-48; *Lininger*, 764 P.2d at 1210.

²⁸¹ *See, e.g., Greco*, 893 P.2d at 347; *Lininger*, 764 P.2d at 1210.

²⁸² *Cockrum v. Baumgartner*, 447 N.E.2d 385, 389 (Ill. 1983) (finding that human life is not a compensable loss). In *Cockrum*, the Supreme Court of Illinois explained, "life should not be outweighed by the expense of supporting it." *Id.* at 389.

²⁸³ Judicial rejection of a "custom made" remedy does not mean that "stock" remedies are unavailable. *See* discussion, *infra* Section V. This is not dissimilar from the legislative rejection of hate crime bills. For example, an individual attacked because of his sexual orientation still has a number of available civil and criminal remedies. Christian Herrmann, *Chapter 98: Deterring Hate Crimes and Enforcing State and Federally Secured Constitutional Rights*, 32 MCGEORGE L. REV. 546, 552 (2000) ("Critics of hate crime legislation also argue that existing law sufficiently addresses violent

2. *Rejection of Private Claims under the PSDA*

Like “wrongful living,” the PSDA seems like a source of patient rights (and thus clinician correlative duties) that is custom designed to address unwanted life-sustaining treatment. Apart from its suggestive title, one of the PSDA’s key objectives is to “ensure compliance with requirements of State law . . . respecting advance directives at facilities of the provider or organization.”²⁸⁴ Therefore, the judicial rejection of private claims under the PSDA,²⁸⁵ like the judicial rejection of “wrongful living,” has a negative symbolic value. It seems tantamount to a wholesale rejection of any legal remedy regarding the right to refuse treatment.

3. *Emergency Exception*

As illustrated by the *Miller* and *Stewart-Graves* cases, the emergency exception seems to permit clinicians to treat patients without consent.²⁸⁶ More precisely, the patient must still consent to treatment.²⁸⁷ In an emergency, the consent is “implied” by the special circumstances.²⁸⁸ When the patient is incapable of consenting and the harm from a failure to treat is both serious and imminent, “it is settled that the impracticality of conferring with the patient dispenses with need for it.”²⁸⁹ In short, a health care provider may deliver life-sustaining treatment “when neither the patient nor an appropriate agent can make the choice pro or con.”²⁹⁰

crime, thereby, making such legislation superfluous.”).

²⁸⁴ Patient Self Determination Act, 42 U.S.C. § 1395cc(f)(1)(D) (2006).

²⁸⁵ See, e.g., *Turner v. Jackson Park Hosp.*, 264 Fed. Appx. 527 (7th Cir. 2008); *Scheible v. Joseph L. Morse Geriatric Ctr., Inc.*, 988 So. 2d 1130, 1132 (Fla. Dist. Ct. App. 2008) (finding “willful disregard of [an] advance healthcare directive” was wrongful prolongation of life); *Asselin v. Shawnee Mission Med. Ctr., Inc.*, 894 F. Supp. 1479, 1483 (D. Kan. 1995) (noting PSDA “requires that certain health care providers maintain written policies and procedures with respect to all adult patients.”).

²⁸⁶ See *supra* notes 249-66 and accompanying text.

²⁸⁷ *HCA, Inc. v. Miller*, 36 S.W.3d 187, 191 (Tex. App. 2000) (explaining that Texas law gives parents right to consent to child’s treatment).

²⁸⁸ DAN B. DOBBS, *THE LAW OF TORTS*, 243-244 (Jesse H. Chopper et al. eds., photo. reprint 2001) (2000) (concluding that it is “not impossible to believe that a patient undergoing an operation consents by implication to extensions of the operation that become medically desirable”). “The patient had impliedly consented to extensions of the operation as appeared necessary in the doctor’s medical judgment during the time the patient was incapacitated by anesthesia.” *Id.* at 248.

²⁸⁹ *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir. 1972).

²⁹⁰ DOBBS, *supra* note 288, at 247.

Indeed, the emergency exception has been successfully invoked in other cases alleging unwanted treatment. Since a patient's need for life-sustaining treatment can often be characterized as an "emergency," it might seem that the exception almost automatically authorizes the administration of life-sustaining treatment independent of and regardless of actual consent in any circumstance. In fact, the emergency exception does have qualifications and limits.²⁹¹ But the judicial application of the exception has more salience than cases in which courts have refused to apply it.²⁹²

4. *Statutory Safe Harbor Immunity*

Perhaps the most common reason that clinicians think that the risk of administering unwanted life-sustaining treatment entails little legal risk, is because many state health care decisions acts expressly grant them permission to deviate from patient instructions.²⁹³

For example, the Minnesota Health Care Directives Act provides that a health care provider who "administers health care necessary to keep the principal alive, despite a health care decision of the health care agent to withhold or withdraw that treatment, is not subject to criminal prosecution, civil liability, or professional disciplinary action."²⁹⁴

²⁹¹ See *infra* notes 441-48 and accompanying text.

²⁹² See, e.g., *Allore v. Flower Hosp.*, 699 N.E.2d 560, 564-65 (Ohio Ct. App. 1997).

²⁹³ See, e.g., ALA. CODE § 22-8A-8(a) (LexisNexis 2006); ARIZ. REV. STAT. ANN. § 36-3205(c) (2009); COLO. REV. STAT. § 15-18-113(5) (2012); CONN. GEN. STAT. ANN. § 19a-580a (West 2011); D.C. CODE § 7-627(b) (LexisNexis 2012); FLA. STAT. ANN. § 765.1105(i) (West 2010); HAW. REV. STAT. ANN. § 327E-7(g) (LexisNexis 2008); IOWA CODE ANN. § 144A.8 (West 2005); KAN. STAT. ANN. § 65-28,107(a) (2002); LA. REV. STAT. ANN. § 40:1299.58.7(D) (Supp. 2013); MD. CODE ANN., HEALTH-GEN. § 5-613(a) (LexisNexis 2009); MO. ANN. STAT. § 459.030 (West 2007); MONT. CODE ANN. § 50-9-203 (2011); NEV. REV. STAT. ANN. § 449.628 (LexisNexis 2009); N.H. REV. STAT. ANN. § 137-J:7(IV) (2005); N.J. STAT. ANN. § 26:2H-65(b) (West 2007); N.D. CENT. CODE § 23-06.5-09(2) (Supp. 2011); OKLA. STAT. ANN. tit. 63, § 3101.9 (West. Supp. 2013); R.I. GEN. LAWS § 23-4.11-7 (2008); S.C. CODE ANN. § 44-77-100 (2002); S.D. CODIFIED LAWS § 34-12D-11 (2011); TENN. CODE ANN. § 32-11-101 (2007); TEX. HEALTH & SAFETY CODE ANN. § 166.045 (West 2010); UTAH CODE ANN. § 75-2a-115(2) (LexisNexis Supp. 2012); VT. STAT. ANN. tit. 18, § 9707(c) (2012); VA. CODE ANN. § 54.1-2987 (2009); WIS. STAT. ANN. § 154.07 (2013); WYO. STAT. ANN. § 35-22-408 (2011).

²⁹⁴ MINN. STAT. § 145C.11 (West 2011). The immunity is conditional. But the conditions are not onerous. The provider must simply take all reasonable steps to:

- (1) notify the health care agent of the health care provider's unwillingness to comply; (2) document the notification in the principal's medical record; and (3) permit the health care agent to arrange to transfer care of the principal to another health care provider willing to comply with the decision of the health

Similarly, Utah's POLST statute provides that a health care provider "is immune from civil or criminal liability, and is not subject to discipline for unprofessional conduct, for . . . providing life sustaining treatment to a person when a life with dignity order directs that the life sustaining treatment be withheld or withdrawn."²⁹⁵ Other states have similar provisions.²⁹⁶

When judicially tested, courts have upheld this statutory immunity. For example, Martha Duarte suffered severe brain injury and was diagnosed as being in a persistent vegetative state.²⁹⁷ The family requested that Martha be removed from the ventilator, but her health care providers refused.²⁹⁸ The family filed suit but the jury found for the defendants.²⁹⁹ The appellate court affirmed, noting that the governing statute grants immunity to a provider who refuses to comply.³⁰⁰

5. *Conscience Clauses*

Often, the safe harbor immunity afforded by a state's health care decisions act provides clinicians with two types of protection. Under these statutes, clinicians may refuse to comply with treatment refusals not only for professional reasons, but also for personal conscience-based reasons.³⁰¹ In addition, many states have separate and independent conscience clauses that protect clinicians' rights to conscience-based objection.³⁰²

care agent.

Id.

²⁹⁵ UTAH CODE ANN. § 75-2a-106(6)(b) (LexisNexis Supp. 2012).

²⁹⁶ See *supra* note 294.

²⁹⁷ Duarte v. Chino Comm. Hosp., 85 Cal. Rptr. 2d 521, 522 (Cal. Ct. App. 1999).

²⁹⁸ *Id.*

²⁹⁹ *Id.*

³⁰⁰ *Id.* at 524; see also Stolle v. Baylor Coll. of Med., 981 S.W.2d 709, 714 (Tex. App. 1998) (holding clinicians immune under statute for providing life-sustaining treatment to brain-damaged child against her parent's instructions).

³⁰¹ See, e.g., CAL. PROB. CODE § 4734(a) (West 2009) ("A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience."); *id.* § 4740(d) ("A health care provider . . . is not subject to civil or criminal liability or to discipline for . . . [d]eclining to comply with an individual health care instruction or health care decision, in accordance with Section[] 4734").

³⁰² See generally *Conscience Clauses*, *supra* note 206, at 172 (outlining the two main types of conscience objection laws and approaches taken by numerous states).

V. Healthcare Providers Have Been Increasingly Sanctioned for Administering Unwanted Life-Sustaining Treatment

In the last Section, I showed that clinicians think there is little legal risk from administering life-sustaining treatment without consent. In this Section, I demonstrate that their perception is wrong. This is likely due to limitations in the published risk assessment literature. These medical and law journal articles are based on a very limited data set.³⁰³ First, commentators base their assessment almost exclusively on courts cases seeking civil damages.³⁰⁴ Second, their court cases are outdated and unrepresentative.

A broader, more thorough and more up-to-date review indicates that the legal risk is significant.³⁰⁵ Health care providers have been increasingly subjected to civil liability for administering unwanted life-sustaining treatment.³⁰⁶ This is hardly the only type of sanction imposed. Providers have also been subjected to disciplinary and criminal sanctions for providing treatment without appropriate authorization.³⁰⁷ Furthermore, recent developments indicate that the severity and frequency of such litigation and regulatory sanctions is increasing.³⁰⁸ This may be, as one legal commentator observed, the “next frontier in healthcare litigation.”³⁰⁹

A. Civil Liability

There is no space, here, to review all the potential theories of civil liability. Accordingly, I focus on the ten most significant causes of action used to address the administration of unwanted life-sustaining treatment. Many of these are tort-based: (1) battery; (2) informed consent; (3) negligence; (4) intentional infliction of emotional distress; and (5) negligent infliction of emotional distress.³¹⁰ Some of these causes of

³⁰³ Indeed, many legal commentators limit their focus not only to civil liability in general but even specifically to claims framed as “wrongful life.” See Alan J. Belsky, *Injury as a Matter of Law: Is This the Answer to the Wrongful Life Dilemma?*, 22 U. BALT. L. REV. 185 (1993); see also Peters, *supra* note 11.

³⁰⁴ See, e.g., Peters, *supra* note 11, at 718 (“[T]he threat of damages constitutes the most significant legal sanction that physicians will realistically face for the violation of patient rights.”).

³⁰⁵ See Pope, *supra* note 15, at 121-22. Just because the risk is significant does not necessarily mean that it is sufficient to deter. *Id.* On the other hand, the perception of even low risk impacts clinician behavior. *Id.* In any case, my primary objective is to demonstrate that the risk is greater than that typically quantified in other assessments.

³⁰⁶ See *infra* discussion Part V.A.

³⁰⁷ See *infra* discussion Parts V.C., V.D.

³⁰⁸ See *infra* discussion Part V.C.3.

³⁰⁹ Parker, *supra* note 49 (quoting Florida State University law professor Lois Shepherd).

³¹⁰ Peters, *supra* note 11, at 684. Plaintiffs have also pursued actions under other tort theories.

action are based on (6) breach of contract. And some are based on statutes such as: (7) health care decisions acts; (8) POLST statutes; (9) Section 1983; and (10) the False Claims Act.³¹¹ Finally, it is important to note (11) the collateral transaction costs involved with litigation even in the absence of liability.

1. Battery

Battery is the most obvious legal theory that a plaintiff would use to recover money damages for the administration of unwanted life-sustaining treatment.³¹² It is a simple tort with just two elements. The clinician is liable ~~for battery~~, if: (1) he or she “acts intending to cause a harmful or offensive contact with the person” and (2) “a harmful [or offensive] contact with person of the other directly or indirectly results.”³¹³ Intent is broadly defined “to denote that the actor desires to cause consequences of his act as well as the situation in which the defendant merely believes the consequences are substantially certain to result from it.”³¹⁴

Medical battery is a well-established intentional tort.³¹⁵ Many still-cited United States precedents date back over a century.³¹⁶ And the elements have barely changed

See, e.g., Afentakis v. Memorial Hosp., 667 N.Y.S.2d 602, 603 (N.Y. 1997) (asserting right of dignity violation); Shine v. Vega, 709 N.E.2d 58, 59 (Mass. 1999) (claiming false imprisonment); Lundman v. McKown, 530 N.W.2d 807, 815 (Minn. Ct. App. 1995) (seeking treatment by Christian Science caused wrongful death); Carol J. Wessels, *Treated with Respect: Enforcing Patient Autonomy by Defending Advance Directives*, 6 MARQUETTE ELDER'S ADVISOR 217, 240-41 (2003) (noting abuse of process).

³¹¹ *See infra* Part V.A.7 – V.A.10. Plaintiffs have also pursued civil actions based on other statutes. *See generally* MEISEL & CERMINARA, *supra* note 25, § 11.08[B] (collecting cases brought under eight different kinds of statutes); Stolle v. Baylor Coll. of Med., 981 S.W.2d 709, 713 (Tex. App. 1998) (bringing claim under Texas Medical Liability and Insurance Improvement Act); Hallada v. Lakeland Reg. Med. Ctr., No. 2103CA-002054 (Polk Cty. Cir. Ct., Fla. Apr. 1, 2013) (alleging claim under vulnerable adult statute).

³¹² *See* Pope & Anderson, *supra* note 20, at 402-07 (analyzing battery claims for unwanted treatment); DiGeronimo v. Fuchs, 927 N.Y.S.2d 904, 908 (N.Y. Sup. Ct. 2011), *affirmed, in part*, 2011-08304, 2012 LEXIS 8613 (N.Y. App. Div. Dec. 19, 2012) (noting that “[a]dministering a blood transfusion without informed consent is best characterized as a battery”) (citing Salandy v. Bryk, 864 N.Y.S.2d 46 (N.Y. App. Div. 2008)).

³¹³ RESTATEMENT (SECOND) TORTS § 13 (1965).

³¹⁴ RESTATEMENT (SECOND) TORTS § 8A (1965).

³¹⁵ Scott v. Bradford, 606 P.2d 554, 557 (Okla. 1979) (stating unauthorized medical treatment constitutes battery); Chambers v. Nottebaum, 96 So. 2d 716, 718 (Fla. Dist. Ct. App. 1957) (characterizing medical operation without patient consent as battery).

³¹⁶ *See, e.g.,* Mohr v. Williams, 104 N.W. 12, 13 (Minn. 1905); Rolater v. Strain, 137 P. 96 (Okla. 1913); Schloendorff v. Soc’y N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

over the past 100 years. These are illustrated in the following colloquy in the *Cruzan* case before the U.S. Supreme Court:

Justice O'Connor: Was the family's consent required at the time for the insertion of the tube? . . . If they had refused that permission, would the state law have required that refusal to be honored?

Mr. Colby: The family's consent was required for the surgery to insert the tube. . . . It would have been a battery for the doctor to perform a surgery without consent.³¹⁷

In short, a battery is established when the clinician acts without any consent whatsoever. And a battery is also established when the clinician acts outside the scope of the patient's consent, whether spatially, temporally, or otherwise.³¹⁸

It does not matter how skillfully or successfully the intervention is provided.³¹⁹

³¹⁷ Oral Argument at 2:59, *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (No. 88-1503), available at http://www.oyez.org/cases/1980-1989/1989/1989_88_1503.

³¹⁸ See, e.g., *Scholendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914) (addressing patient consented to biopsy, not surgery); *Pizzalotto v. Wilson*, 437 So. 2d 859 (La. 1983) (addressing patient consented to exploratory surgery, not removal of reproductive organs); *Perna v. Pirozzi*, 457 A.2d 431 (N.J. 1983) (consenting to operation with only one specific doctor); *Paulsen v. Gunderson*, 260 N.W. 448 (Wis. 1935) (analyzing patient consent to a "simple" ear operation, and instead underwent a "radical" ear operation); *Franklyn v. Peabody*, 228 N.W. 681 (Mich. 1930) (operating on thumb without consent); *Gill v. Selling*, 267 P. 812 (Ore. 1928) (performing spinal puncture on wrong patient), *overruled by* *Fredeen v. Stride*, 525 P.2d 166 (Ore. 1974); *Hively v. Higgs*, 253 P. 363 (Ore. 1927) (noting removal of tonsils during septum operation); *Hershey v. Peake*, 223 P. 1113 (Kan. 1924) (concerning wrong tooth); *Throne v. Wandell*, 186 N.W. 146 (Wis. 1922) (addressing patient consent to examination, not extraction of six teeth); *Moos v. U.S.*, 225 F.2d 705 (8th Cir. 1955) (operating on wrong leg); *Kaplan v. Mamelak*, 75 Cal. Rptr. 3d 861 (Cal. Ct. App. 2008) (operating on wrong spinal disk); *Perry v. Shaw*, 106 Cal. Rptr. 2d 70, 72 (Cal. Ct. App. 2001) (concerning patient consent to removal of excess skin, not breast augmentation); *Ashcraft v. King*, 278 Cal. Rptr. 900 (Cal. Ct. App. 1991) (analyzing patient imposed condition on consent); *Bommareddy v. Superior Ct.*, 272 Cal. Rptr. 246 (Cal. Ct. App. 1990) (concerning patient agreed to tear duct surgery, not cataract extraction); *Lane v. U.S.*, 225 F. Supp 850 (E.D. Va. 1964) (addressing surgery on wrong knee); Allan H. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957).

³¹⁹ See, e.g., *Mohr*, 104 N.W. at 15 (requiring consent in non-emergency situations), *overruled in part by* *Genzel v. Halvorson*, 80 N.W.2d 854 (Minn. 1957); RESTATEMENT (SECOND) OF TORTS §§ 892, illus. 1, at 435 (1965); see also *Montgomery v. Bazaz-Seghal*, 742 A.2d 1125, 1130 (Pa. Super. Ct. 1999), *aff'd*, 798 A.2d 742 (Pa. 2002) (discussing urologist implanted penile prosthesis without patient's knowledge or consent); *Taylor v. Johnston*, 985 P.2d 460 (Alaska 1999) (obtaining patient consent by fraud); *Millard v. Nagle*, 587 A.2d 10 (Pa. 1991) (seeking damages for

It does not matter that the administration of treatment is beneficial on balance.³²⁰ Nor does it matter if the clinician's intent was to benefit the patient.³²¹ Whether that

unauthorized surgery despite physician intention); *Perna v. Pirozzi*, 457 A.2d 431, 439 (N.J. 1983) (“A nonconsensual operation remains a battery even if performed skillfully and to the benefit of the patient.”); *Pugsley v. Privette*, 263 S.E.2d 69 (Va. 1980) (holding that unconsented medical treatment constitutes a battery, even though such medical treatment may be beneficial to the plaintiff); *Rogers v. Lumpersmens Mut. Casualty Co.*, 119 So. 2d 649 (La. 1960); *Genzel v. Halvorson*, 80 N.W.2d 854 (Minn. 1957) (performing surgery without consent is battery); *Kennedy v. Parrott*, 90 S.E.2d 754 (N.C. 1956) (analyzing causation between doctor's action and patient's harms in battery action); *Franklyn v. Peabody*, 228 N.W. 681 (Mich. 1930) (operating on patient's right thigh without consent to obtain tissue for a procedure on patient's thumb constitutes battery); *Perry v. Hodgson*, 148 S.E. 659 (Ga. 1929) (noting patient consent required unless emergency); *Barrette v. Lopez*, 725 N.E.2d 314 (Ohio Ct. App. 1999) (distinguishing medical negligence from battery); *Rodriguez v. Pino*, 634 So. 2d 681 (Fla. Dist. Ct. App. 1994) (holding physician not liable for patient's refusal to consent); *Lounsbury v. Capel*, 836 P.2d 188, 199 (Utah Ct. App. 1992) (remanding for damages even though surgery somewhat beneficial); *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1051 (Ohio Ct. App. 1984) (“A physician who treats a patient without consent commits a battery, even though the procedure is harmless or beneficial.”); *Mims v. Boland*, 138 S.E.2d 902 (Ga. Ct. App. 1964) (recognizing physician treatment without consent is guilty of technical battery); *McCandless v. State*, 162 N.Y.S.2d 570 (N.Y. App. Div. 1957) (affirming \$2,000 in damages even though procedure less harmful and improved patient's mental health); *Church v. Adler*, 113 N.E.2d 327 (Ill. App. Ct. 1953) (reviewing cause of medical negligence); *Mulloy v. Hop Sang*, 1 W.W.R. 714 (Can. A.R. 1935) (holding that even a successful operation, contrary to patient instructions, was still a battery).

³²⁰ DOBBS, *supra* note 288, at 80 (“Even beneficial touchings such as medical procedures may warrant damages if they are batteries.”). The Second Restatement of Torts provides an applicable example:

A has a wart on his neck. His physician, B, advises him to submit to an operation for its removal. A refuses to do so. Later A consents to another operation B removes the wart. The removal in no way affects A's health, and is in fact beneficial. A has suffered bodily harm.

RESTATEMENT (SECOND) OF TORTS § 15, illus. 1 (1965).

³²¹ MEISEL & CERMINARA, *supra* note 25, at § 2-24 n.104; *Chambers v. Nottebaum*, 96 So. 2d 716 (Fla. Dist. Ct. App. 1957) (concerning lack of consent for spinal anesthesia); *Corn v. French*, 289 P.2d 173 (Nev. 1955) (alleging mastectomy without consent); *Woodson v. Huey*, 261 P.2d 199 (Okla. 1953) (affirming need for consent to give anesthesia); *Tabor v. Scobee*, 254 S.W.2d 474 (Ky. Ct. App. 1952) (addressing removal of fallopian tubes during operation for appendicitis); *Williams*, 104 N.W. at 15-16 (discussing operation on left ear but consent obtained only for right ear), *overruled in part by* *Genzel v. Halvorson*, 80 N.W.2d 854 (Minn. 1957); *Rolater v. Strain*, 137 P. 96 (Okla. 1913) (addressing removal of sesamoid bone without consent); *Hively v. Higgs*, 253 P. 363 (Or. 1927) (addressing removal of tonsils with only consent for septum surgery); *Wells v. Van Nort*, 125 N.E. 910 (Ohio 1919) (analyzing physician decision to remove fallopian tubes); *Schloendorff v. Soc'y N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914) (addressing unauthorized surgery), *abrogated by* *Bing v. Thunig*, 143 N.E.2d 3 (1957); *Sekerez v. Rush Univ. Med. Ctr.*, 954 N.E.2d

treatment constitutes a “benefit” is a value judgment for the patient to make. The clinician knows that intervention is harmful. Many of these procedures are “highly intrusive, and some are violent in nature.”³²² Or the clinician at least knows that, without consent, the treatment would be offensive, infringing on reasonable sense of personal dignity.³²³ In short, neither “good” motives nor “good” results are relevant to a finding of battery.³²⁴

A cause of action for battery is particularly attractive to a plaintiff. First, she does not need to establish a standard of care.³²⁵ Consequently, she does not need to retain any expert witnesses.³²⁶ Second, while the plaintiff likely will be able to prove

383 (Ill. App. Ct. 2011) (reversing directed verdict for defendants who administered Lovenox to terminally ill cancer patient against his stated and documented wishes); *Gragg v. Calandra*, 696 N.E.2d 1282, 1290 (Ill. App. Ct. 1998) (“Although a defendant may reasonably believe that his objective is legitimate, it does not provide him with carte blanche to pursue that objective by outrageous means.”); *Kaplan v. Blank*, 419 S.E.2d 127 (Ga. Ct. App. 1992) (claiming lack of written consent for tubal ligation); *Markart v. Zeimer*, 227 P. 683 (Cal. Ct. App. 1924) (reviewing negligence in hernia surgery).

³²² *In re Dinnerstein*, 380 N.E.2d 134, 135-36 (Mass. App. 1978); see also MEISEL & CERMINARA, *supra* note 25, § 6.02 (collecting cases); see *Markart v. Zeimer*, 227 P. 683 (Cal. App. 1924) (concerning removal of testicle).

³²³ DOBBS, *supra* note 288, § 33, at 81 (“It is enough that the defendant intends bodily contact that is ‘offensive,’ which is to say a bodily contact that does not appear acceptable to the plaintiff.”); Nancy J. Moore, *Intent and Consent in the Tort of Battery: Confusion and Controversy*, 61 AM. U. L. REV. 1585, 1595 (2012); HORACE, *ARS POETICA* 467 (Transl. A.S. Kline 2005) (“[W]ho saves one, against his will, murders him”).

³²⁴ Moore, *supra* note 323, at 1611, 1621; *Curtis v. Jaskey*, 326 Ill. App. 3d 90, 94 (2001) (noting that it is unnecessary for plaintiff to prove defendant physician had hostile intent); *McNeil v. Brewer*, 304 Ill. App. 3d 1050, 1154-55 (1999).

³²⁵ DOBBS, *supra* note 288, at 342 (“Even beneficial . . . medical procedures warrant damages if they are batteries.”). “A person is entitled to refuse well-intentioned medical treatment.” *Id.* § 29, at 54; see *Urlaub v. Select Specialty Hosp. Memphis*, No. W2010-00732-COA-R3-CV, 2011 WL 255281 1, 6 (Tenn App. Jan. 20, 2011) (administering dialysis contrary to instructions could constitute a battery by not following the standard of care necessitated by informed consent); *Mink v. Univ. Chicago*, 460 F. Supp. 713, 717 (N.D. Ill. 1978); *Beane v. Perley*, 109 A.2d 848, 850 (N.H. 1954) (recognizing the difficulty in providing medical expert testimony as required in malpractice suits). *But see* *Pleasure v. Louisiana Organ Procurement Ass’n*, 83 So. 3d 174 (La. App. 2011) (affirming judgment that continuing life-support and removing organs without consent sounded in medical malpractice), *rev. denied*, 85 So. 3d 1248 (La. 2012). While the conferral of “benefit” by the unwanted treatment does not effect the cause of action, it is considered in determining the amount of the award. FOWLER V. HARPER ET AL., HARPER, JAMES AND GRAY ON TORTS 348 (3d ed. 2006). Nevertheless, it is problematic to characterize as a “benefit” a state of life the person living that life finds intolerable.

³²⁶ As litigation costs decrease, clinician compliance rates should rise. Keith N. Hylton, *Litigation Cost Allocation Rules and Compliance with the Negligence Standard*, 22 J. LEG. STUDIES 457, 459 (1993).

damages she does not need to establish any.³²⁷ She can recover nominal and punitive damages without showing any compensatory damages.³²⁸ Third, she need not navigate tort reform procedural hurdles such as damages caps and pre-filing review.³²⁹ Fourth, the prospect of damages sends a very powerful signal, because a judgment or settlement may not be covered by insurance.³³⁰

Perhaps the most notable battery lawsuit over the administration of unwanted life-sustaining treatment involved Brenda Young. In 1996, a Michigan jury awarded \$16.5 million for keeping Brenda on life support for over two months.³³¹ This amount included the patient's pain and suffering, the mother's mental anguish, a sister's mental anguish, and future medical expenses. The trial court reduced this amount to \$1.4 million, and the case was later settled.³³²

³²⁷ DOBBS, *supra* note 288, at § 42, at 79 (“When the trespassory tort causes no physical harm, the traditional tort rule is that the plaintiff can nevertheless recover substantial as distinct from nominal damages. . . . The invasion of the plaintiff’s rights is regarded as harm in itself. . . .”); *id.* § 100, at 234 n.17 (“The difference is that a battery is actionable without proof of bodily harm or economic loss; the offensive touching is harm in itself.”); *id.* § 28, at 54 (“Battery today vindicates the plaintiff’s rights of autonomy and self-determination, her right to decide for herself how her body will be treated by others”); *B v. NHS Hosp. Trust* [2002] EWHC 429 (awarding £100 nominal damages).

³²⁸ *See, e.g., Whitley-Woodford v. Jones*, 600 A.2d 946, 947-48 (N.J. Super. Ct. App. Div. 1992) (noting that an operation undertaken without consent, even if perfectly performed with good medical results, may entitle the plaintiff to at least nominal damages and even punitive damages).

³²⁹ This has been confirmed in battery cases involving life-sustaining treatment. *See generally* RICHARD E. SHANDELL & PATRICIA SMITH, *THE PREPARATION AND TRIAL OF MEDICAL MALPRACTICE CASES* § 1.06[6] (2006); *Gragg v. Calandra*, 696 N.E.2d 1282, 1286 (Ill. App. 1998); *Russell v. Murphy*, 86 S.W.3d 745, 748-50 (Tex. App. 2002) (holding medical standards irrelevant where anesthesiologist administered sedative despite patient’s specific request for local anesthetic); *Jones v. Ruston La. Hosp. Co.*, 71 So. 3d 1154 (La. App. 2011) (holding Medical Malpractice Act and review by “medical review panel” inapplicable where clinician resuscitated Agnes Liles despite “knowledge of the DNR order”); *Abeyta v. HCA Health Servs. of Tenn.*, No. M2011-02254-COA-R3-CV, 2012 WL 5266321 (Tenn. App. Oct. 24, 2012) (having not filed a certificate of good faith did not amount to malpractice, but ordinary negligence, not requiring expert testimony). *But cf. Shuler v. McGrew*, No. 12-2003-STA-dkv, 2012 WL 3260685 1, 6 (W.D. Tenn. Aug. 8, 2012) (holding that administration of Heparin over patient’s objections was not battery because it was a “component part of the treatment process” and providers had patient’s consent to be treated at the hospital).

³³⁰ HARPER ET AL., *supra* note 325, § 3.10, at 351.

³³¹ *Osgood v. Genesys Regional Med. Ctr.*, No. 94-26731-NH (Genesee Cty. Cir. Ct., Mich. Mar. 7, 1997). While reversed on appeal, the Millers’ \$60 million verdict against HCA is still notable. *See supra* note 254.

³³² *Osgood v. Genesys Regional Med. Ctr.*, No. 94-26731-NH (Genesee Cty. Cir. Ct., Mich. Feb. 16, 1996); *Rodriguez, supra* note 11, at 31.

The Brenda Young case is not unique. Other plaintiffs have also recovered damages in battery actions. For example, in *Lunsford v. UCSF Medical Center*, a San Francisco jury awarded \$500,000 to the parents of a child transfused against parental wishes.³³³ Similarly, in *Malette v. Shulman*, the court upheld an award of \$20,000 where the patient “suffered mentally and emotionally” from getting a blood transfusion contrary to her written instructions.³³⁴ And in *Leach v. Shapiro*, clinicians refused a guardian’s request to remove the ventilator from his wife who was in a persistent vegetative state.³³⁵ The hospital settled for \$50,000.³³⁶

In 2011, the Louisiana Court of Appeals permitted a battery claim to proceed.³³⁷ The patient’s daughters had sued the hospital for its failure to abide the patient’s DNR order. The daughters alleged that despite knowledge of the DNR order, hospital employees resuscitated their father, who suffered physical limitations and disabilities requiring rehabilitation until his ultimate death two months later. The case is now in discovery.³³⁸ The daughters are seeking damages for the medical expenses attributable to his post-resuscitation care, physical and mental pain and suffering, loss of enjoyment of life, and cognitive decline.

2. Informed Consent

While battery concerns the administration of treatment without consent, an informed consent cause of action presumes that the patient actually did consent to the treatment.³³⁹ In an informed consent action, the patient concedes that she consented.³⁴⁰

³³³ No. 837936 (San Francisco Super. Ct. Apr. 13, 1990); Steven A. Chin, *Family of Blood Recipient Wins \$500,000*, SAN FRANCISCO EXAMINER, Apr. 20, 1990, available at <http://www.deseretnews.com/article/98173/FAMILY-OF-BLOOD-RECIPIENT-WINS-500000.html?pg=all>. Although overturned by post-trial motions and affirmed on appeal, the case was settled for an amount in excess of six figures. The McCabe Law Firm, APC, <http://www.mccabelaw.net/docs/cv.html> (last visited Apr. 30, 2013).

³³⁴ *Malette v. Shulman* (1990), 72 O.R. 2d 417 (Can. Ont. C.A.).

³³⁵ *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1051 (Ohio Ct. App. 1984).

³³⁶ Vicki Joiner Bowers, Comment, *Advance Directives: Peace of Mind or False Security?*, 26 STETSON L. REV. 677, 702 n.138 (1996).

³³⁷ *Jones v. Ruston La. Hosp. Co.*, 71 So. 3d 1154, 1157 (La. Ct. App. 2011).

³³⁸ E-mail from Kurt S. Blankenship, Partner, Blue Williams, LLP, to Professor Thaddeus M. Pope, Director of the Health Law Institute and Associate Professor, Hamline University School of Law (Dec. 24, 2012) (on file with author).

³³⁹ See *Leach*, 469 N.E.2d at 1052 (discussing informed consent requirement for treatment). “There is no legal defense to battery based on consent if a patient’s consent to touching is given without sufficient knowledge and understanding the nature of the touching.” *Id.*

³⁴⁰ See *id.* at 1054 (discussing ramifications of failure to disclose material information about

But the patient argues that she would not have consented had the clinician disclosed relevant information that the clinician had a legal duty to disclose.³⁴¹ Sometimes, the clinician's failure to obtain adequate informed consent is deliberate. For example, the clinician might intentionally distort the patient's prognosis to get consent.³⁴² More commonly, the clinician's failure to obtain informed consent is inadvertent.³⁴³

Traditionally, informed consent actions have been a form of medical negligence.³⁴⁴ But, increasingly, states have been enacting statutes that specifically mandate clinicians to disclose end-of-life treatment options.³⁴⁵ California, for example, provides that when a health care provider makes a diagnosis that a patient has a terminal illness, the provider "shall, upon the patient's request, provide the patient with comprehensive information and counseling regarding legal end-of-life care options."³⁴⁶

patient's condition). Where plaintiffs acting on patient's behalf were not fully informed of the patient's condition during two months of treatment, the court acknowledged that a failure to disclose material information of a patient's condition may be actionable even if consent was given. *Id.*

³⁴¹ See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 305 (Cal. Dist. Ct. App. 1986) ("It is incongruous, if not monstrous, for medical petitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure . . ."); HARPER ET AL., *supra* note 325, § 17.1, at 627 ("The very foundation of the doctrine is everyone's right to forgo treatment or even cure if it entails what *for him* are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession . . .").

³⁴² Billings, *supra* note 50, at 597; Helen Harrison, *The Offer They Can't Refuse: Parents and Perinatal Treatment Decisions*, 13 SEMINARS FETAL & NEONATAL MED. 329 (2008); JAMES L. BERNAT, *ETHICAL ISSUES IN NEUROLOGY* 172 (3d ed. 2008). The line between a strong recommendation and coercion at times may be hard to draw; "Physicians should not threaten patients or surrogates, [and] not exaggerate facts . . ." *Id.* (footnote omitted); see also *Marshall v. Catholic Health Initiatives*, No. 11CI00972 (27th Jud. Cir. Ct., Ky. Sept. 11, 2011) (alleging a number of medical providers performed unnecessary heart procedures).

³⁴³ It is difficult to establish causation in informed consent cases because the plaintiff must establish that, with disclosure, a reasonable person would not have consented to the treatment. This can be especially challenging in life-saving cases. See, e.g., *Patient Loses Suit Against Doctor Who Saved His Life*, L.A. TIMES, July 9, 1996, at A20, available at http://articles.latimes.com/1996-07-09/news/mn-22442_1_tracheotomy (suggesting the jury concluded that the patient changed his mind).

³⁴⁴ DOBBS, *supra* note 288, at 654.

³⁴⁵ See statutes cited *supra* note 190. Other states have been exploring similar legislation. See, e.g., S.B. 1447, 50th Leg., 1st Reg. Sess. (Ariz. 2011) (listing end-of-life options for terminally ill patients); S.B. 1298, 49th Leg., 2nd Reg. Sess. (Ariz. 2010) (listing end-of-life options for terminally ill patients in healthcare institutions); H.B. 30, 249th Leg., 1st Reg. Sess. (Md. 2009) (urging Attorney General to convene work group to make recommendations for end-of life care).

³⁴⁶ CAL. HEALTH & SAFETY CODE § 442.5 (2009); see also *supra* note 190 and accompanying text on similar statutes.

This crystallizes the clinician's duty in this way should make it easier to enforce.³⁴⁷

3. Negligence

If the clinician is unaware of the patient's advance directive or other refusal, then the plaintiff probably cannot establish the requisite intent for battery.³⁴⁸ But the patient might still be able to establish negligence. In order to establish that a clinician negligently failed to comply with a refusal of treatment, the plaintiff must show: (1) that the clinician had a duty to care for the patient in accord with her expressed preferences; (2) that the clinician breached that duty, deviating from the relevant standard of care; (3) that the patient suffered damages; and (4) that those damages were caused by the breach.³⁴⁹

The clinician's ignorance of the patient's instructions may be negligence.³⁵⁰ For example, in *Anderson v. St. Francis/St. George Hosp.*, when 82-year-old Edward Winter was admitted to the hospital for cardiac insufficiency, he authorized his family physician to enter a "no code blue" in his chart.³⁵¹ Just a few days later, Mr. Winter had an episode of a type of irregular heart rhythm.³⁵² A hospital nurse, apparently unaware of the "no code blue" order, resuscitated Mr. Winter by defibrillation.³⁵³ While the nurse is unlikely to be personally liable for battery,³⁵⁴ the court noted that Mr. Winter's battery and negligence claims were valid (presumably against the facility).³⁵⁵ Winter's medical

³⁴⁷ See, e.g., *Hargett v. Vitas Healthcare Corp.*, No. RG10547255 (Alameda Cty. Super. Ct., Cal. filed July 6, 2011).

³⁴⁸ DOBBS, *supra* note 288, § 28, at 53 ("An accidental touching may count as negligence, but it is not a battery."); *Allore v. Flower Hosp.*, 699 N.E.2d 560 (Ohio Ct. App. 1997). Cf. *Hulver v. U.S.*, 393 F. Supp. 749 (W.D. Mo. 1975); *Gaskin v. Goldwasser*, 520 N.E.2d 1085 (Ill. App. Ct. 1988); *Hogan v. Morgan*, 960 So. 2d 1024 (La. Ct. App. 2007); *Wooley v. Henderson*, 418 A.2d 1123 (Me. 1980); *Moore*, *supra* note 323, at nn.321-32.

³⁴⁹ WILLIAM LLOYD PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 30 (4th ed. 1971).

³⁵⁰ See *Anderson v. St. Francis-St. George Hosp.*, 614 N.E.2d 841, 843 (Ohio Ct. App. 1992) (claiming undesired resuscitation of patient was negligence that prevented natural death). The claim for negligence was premised on the failure to properly record the DNR order. David Margolick, *Patient's Lawsuit Says Saving Life Ruined It*, N.Y. TIMES, Mar. 18, 1990, at 1, available at <http://www.nytimes.com/1990/03/18/us/patient-s-lawsuit-says-saving-life-ruined-it.html>.

³⁵¹ *Anderson*, 614 N.E.2d at 843.

³⁵² *Id.*

³⁵³ *Id.*

³⁵⁴ See *Allore v. Flower Hosp.*, 699 N.E.2d 560, 564-66 (Ohio Ct. App. 1997) (explaining affirmation of summary judgment on issue of negligence).

³⁵⁵ *Anderson*, 614 N.E.2d at 844.

directives “were ignored, either negligently or intentionally.”³⁵⁶

Other theories of negligence have focused on providers’ failure to consult the patient’s reasonably available surrogate.³⁵⁷ At the facility level, plaintiffs have focused on providers’ failure to draft, adopt, or implement adequate policies to elicit, record, and convey patients’ treatment preferences.³⁵⁸ Furthermore, the negligence per se doctrine may also be applied based upon violations of relevant statutes, regulations, and ordinances.³⁵⁹

When an incapacitated patient has no documented refusal of treatment, then the clinician who later administers such treatment may not be personally culpable for overriding the patient’s refusal.³⁶⁰ The clinician did not even know about the refusal.³⁶¹ On the other hand, ignorance is not bliss. The clinician may be negligent for failing to consult or examine the patient’s medical records.³⁶² And it is probable that the facility is negligent for failing to properly maintain medical records.³⁶³

³⁵⁶ Anderson v. St. Francis-St. George Hosp., No. C-930819, 1995 WL 109128, at *3 (Ohio Ct. App. Mar. 15, 1995).

³⁵⁷ See, e.g., Complaint, Noval v. Kaiser Fdn. Hosp., No. RIC-1201608 (Riverside Cty. Super. Ct., Cal., filed Feb. 2, 2012); Morgan v. Olds, 417 N.W.2d 232 (Iowa App. 1987).

³⁵⁸ See, e.g., Kranson v. Valley Crest Nursing Home, 755 F.2d 46, 48-49 (3d Cir. 1985); see also Self v. Milyard, No. 11-CV-00813-RBJ-CBS, 2012 WL 1602104 (D. Colo. 2012); Callison v. Hillcrest Healthcare System, No. CJ-2010-319, 2011 WL 7990001 (D. Okla. 2011); Clark v. Perry, 442 S.E.2d 57 (N.C. App. 1994); Marasovic v. Eberhard, No. A106356, 2006 WL 367349 (Cal. Ct. App. Feb. 16, 2006); Furlong v. Catholic Healthcare West, No. B172067, 2004 WL 2958274 (Cal. App. Dec. 22, 2004); Hallada v. Lakeland Reg. Med. Ctr., No. 2103CA-002054 (Polk Cty. Cir. Ct., Fla. Apr. 1, 2013) (Complaint).

³⁵⁹ Cf. Whaley v. Perkins, 197 S.W.3d 665, 672-73 (Tenn. 2006). Several applicable health care facility standards might support such a cause of action. See *infra* Sections V.A.7 & V.C.

³⁶⁰ Allore v. Flower Hosp., 699 N.E.2d 560, 565 (Ohio Ct. App. 1997) (declining to find physicians negligent for resuscitating patient when no evidence of DNR in chart); Wright v. Johns Hopkins Health Sys. Corp., 728 A.2d 166, 176 (Md. 1999) (upholding summary judgment for physicians because patient’s oral directive declining resuscitation not in medical records).

³⁶¹ R. Sean Morrison et al., *The Inaccessibility of Advance Directives on Transfer from Ambulatory to Acute Care Settings*, 274 JAMA 478, 480 (1995) (finding advance directives documented in only 26% of charts); Cynthia J. Stolman et al., *Evaluation of Patient, Physician, Nurse, and Family Attitudes toward Do Not Resuscitate Orders*, 150 ARCHIVES INTERNAL MED. 653, 653 (1990) (stating only 26% of advanced directives are recognized).

³⁶² See Adam A. Milani, *Better Off Dead Than Disabled?: Should Courts Recognize a “Wrongful Living” Cause of Action When Doctors Fail to Honor Patients’ Advance Directives?*, 54 WASH. & LEE L. REV. 149, 225 n.355 (1997) (collecting cases where failure to examine records was negligent); cf. McVey v. Englewood Hosp. Ass’n, 524 A.2d 450, 452 (N.J. Super. Ct. App. Div. 1987) (declining physician liability for failure to honor undocumented oral request to terminate patient’s life support).

³⁶³ See A. Samuel Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of*

4. *Intentional Infliction of Emotional Distress*

The tort of intentional infliction of emotional distress ("IIED") has four elements: (1) the defendant must act intentionally or recklessly; (2) his or her conduct must be extreme and outrageous; and (3) the conduct must be the cause-in-fact (4) of plaintiff's severe emotional distress.³⁶⁴ Conduct is deemed "extreme and outrageous" if it is "so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community."³⁶⁵

Early IIED cases over unwanted treatment were often unsuccessful, because "ethical and legal norms concerning a patient's right to terminate life-preserving treatment were [still] uncertain."³⁶⁶ Consequently, courts were "less likely to find the conduct of defendant health care providers to be extreme or outrageous."³⁶⁷ For example, in one of the earliest reported cases, the court took into account the "uncertain medical and legal climate" to conclude that the defendant's conduct was not extreme or outrageous.³⁶⁸

In contrast, statutory and common law in this area is now both clear and well-established.³⁶⁹ Today, it is, therefore, far easier to show that a clinician's acts in

Action, 75 GEO. L.J. 625, 661 n.160 (1986) ("The responsibility of knowing the contents of a patient's medical records should not be an undue burden for hospital medical personnel."); see *infra* notes 449, 483-495 and accompanying text (reviewing facility inspections and citations for inadequate record maintenance pertaining to end-of-life decisions).

³⁶⁴ RESTATEMENT (SECOND) OF TORTS § 46 (1965).

³⁶⁵ RESTATEMENT (SECOND) OF TORTS § 46 cmt. d (1965).

³⁶⁶ Wherthey, *supra* note 230, § 5.

³⁶⁷ *Id.*

³⁶⁸ *Bartling v. Glendale Adventist Med. Ctr.*, 229 Cal. Rptr. 360, 363 (Cal. Ct. App. 1986) (finding medical professionals acted in reliance on what they believed to be "prevailing community" standards). In *Bartling*, the court explained that it "cannot agree that the Bartlings' rights were so-well defined at the time of Mr. Bartling's hospitalization that [hospital] acted with 'conscious disregard'" *Id.* at 363; see also *Foster v. Tourtellote*, 704 F.2d 1109, 1113 (9th Cir. 1983) (observing that "the government faced a complete absence of helpful precedent"); *Ross v. Hilltop Rehab. Hosp.*, 676 F. Supp. 1528, 1534-35 (D. Colo. 1987) ("[c]luded area of the law"); *Strachan v. John F. Kennedy Mem'l. Hosp.*, 507 A.2d 718, 723-27 (N.J. Super. Ct. App. Div. 1986) (reversing \$140,000 verdict for NIED; but, remanding for new trial); *Grace Plaza of Great Neck v. Elbaum*, 588 N.Y.S.2d 853, 880 (N.Y. App. Div. 1992). "[U]nder the law as it stood at the time this case arose, [the long term care facility] committed no legal wrong . . . in the absence of judicial guidance . . ." *Id.* at 860.

³⁶⁹ See *supra* Section II. In this instance, Oliver Wendell Holmes was right: legal standards do become clearer over time. OLIVER WENDELL HOLMES, *THE COMMON LAW* 111-29 (1881).

providing unwanted treatment are extreme and outrageous.³⁷⁰ For example, in *Campbell v. Delbridge*, the court reversed summary judgment that the trial court had granted in favor of a clinician and hospital that had transfused a Jehovah's Witness against her wishes.³⁷¹

In *Gragg v. Calanda*, the patient underwent open-heart surgery and was placed on life support contrary to his advance directive.³⁷² Moreover, the clinicians not only contradicted the patient's instructions, but also abused and insulted family members, "accusing them in a public area" of trying to kill the patient.³⁷³ The clinician knew or had reason to know that the family members were "extremely distraught" because of the patient's condition.³⁷⁴ The court concluded there was a "high probability" that severe emotional distress would follow and that the clinician "consciously disregarded it."³⁷⁵

Emboldened by this favorable precedent, plaintiffs continue to assert IIED claims when clinicians administer unwanted life-sustaining treatment. For example, the leading end-of-life advocacy organization, Compassion & Choices, recently filed *DeArmond v. Permanente Medical Group*.³⁷⁶ Emily DeArmond had been ill her entire life due to brain cancer.³⁷⁷ In August 2010, her mother completed a POLST ordering "Do Not Intubate."³⁷⁸ A few weeks later, in November 2010, Emily's mother found her in bed unresponsive.³⁷⁹ An ambulance transported Emily to Kaiser Medical Center, where an emergency room physician intubated Emily despite the POLST.³⁸⁰

Emily's family filed a lawsuit for damages in the Superior Court of Orange County, California, alleging causes of action for, among other things, intentional

³⁷⁰ MEISEL & CERMINARA, *supra* note 25, at ch. 11 § 11.01[A]. *But see* Westhart v. Mule, 261 Cal. Rptr. 640 (Cal. Ct. App. 1989) (dismissing IIED claim because wife took no action to have her husband's tube removed).

³⁷¹ *Campbell v. Delbridge*, 670 N.W.2d 108, 113 (Iowa 2003); *see also* *DiGeronimo*, 927 N.Y.S.2d at 908 (suggesting that Jehovah Witness plaintiff should have plead IIED).

³⁷² *Gragg v. Calanda*, 696 N.E.2d 1282, 1285 (Ill. App. Ct. 1998).

³⁷³ *Id.* at 1289.

³⁷⁴ *Id.* at 1290.

³⁷⁵ *Id.*

³⁷⁶ Complaint at 1, *DeArmond v. Permanente Med. Group*, No. 30-2011-00520263 (Cal. Super. Ct. Nov. 3, 2011), *available at* http://thaddeuspope.com/images/DeArmond_OCSC_11-03-11_complaint_.pdf (alleging IIED on plaintiff by defendant doctor when he administered unwanted end of life treatment to plaintiff's now deceased daughter).

³⁷⁷ *Id.* at 7.

³⁷⁸ *Id.* at 8.

³⁷⁹ *Id.* at 9.

³⁸⁰ *Id.*

infliction of emotional distress and negligent infliction of emotional distress.³⁸¹ In May 2012, the court granted Kaiser's petition to compel arbitration of the dispute.³⁸² While the DeArmond family may still prevail on the merits, it will be without the publicity or transparency that normally attends litigation.³⁸³

5. *Negligent Infliction of Emotional Distress*

Even if a plaintiff cannot establish the elements of IIED, she might still be able to establish the less demanding elements of negligent infliction of emotional distress ("NIED"). NIED requires the plaintiff to establish: (1) that the defendant engaged in conduct that she should have realized involved an unreasonable risk of causing emotional distress; and (2) that the conduct caused emotional distress to the plaintiff.³⁸⁴

Either the patient or her family member could bring a claim for NIED. The patient could maintain an action for NIED arising out of fear for her own personal

³⁸¹ *Id.* at 10. The complaint also alleged: (1) neglect of a dependent adult; (2) deceptive and unfair trade practices; (3) violation of the Health Care Decisions Act; and (4) violation of the California Consumer Legal Remedies Act. *DeArmond*, No. 30-2011-00520263 at 36-38.

³⁸² *Civil Case Access*, SUPERIOR COURT OF CALIFORNIA, COUNTY OF ORANGE, <https://ocapps.occourts.org/civilwebShopping/ShowCase.do#top> (last visited Apr. 30, 2013) (case activity listed under Register of Actions).

³⁸³ The *DeArmond* case illustrates a broader phenomenon. Many hospitals and long-term care facilities have mandatory pre-treatment arbitration clauses. *See, e.g.*, Adam S. Levine, *I Need a Lawyer to See My Doctor: Pre-Treatment Mandatory Arbitration Agreements as a Condition Precedent to Receiving Medical Care in Florida*, 7(2) ABA HEALTH ESOURCE (Oct. 2010), https://www.americanbar.org/newsletter/publications/aba_health_esource_home/Volume7_02_levine.html. This reduces the visibility of claims for unwanted treatment. But it does not mean that there are no settlements and awards. Plaintiffs' attorneys normally will not take medical malpractice cases valued under \$250,000. *See* Joanna Shepherd, *Justice in Crisis: Victim Access to the American Medical Liability System*, 67 VAND. L. REV. (forthcoming 2014), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2147915###. That means injured individuals effectively lose their access to court. *See* David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1102 (2006). But plaintiffs are still likely to bring IIED cases. First, they may be simpler and cheaper to try. Second, some plaintiffs may even pay by the hour. Third, plaintiffs often bring lawsuits where transaction costs exceed expected monetary recovery. *See, e.g.*, *Fisher v. Carrousel Motor Hotel, Inc.*, 424 S.W.2d 627 (Tex. 1967); *Slocum v. Food Fair Stores of Florida*, 100 So. 2d 396 (Fla. 1958); *Dougherty v. Stepp*, 18 N.C. 371 (1835). Fourth, even if there were insufficient incentives to bring most unwanted treatment cases, that would not be different from medical malpractice. Most medical errors of all types do not get litigated. But this hardly means that the medical malpractice system exerts no deterrent signal or quality incentive.

³⁸⁴ *Molien v. Kaiser Found. Hosp.*, 616 P.2d 813, 816-18 (Cal. 1980).

safety as a result of the defendant's negligent act.³⁸⁵ In addition, with the widespread abolition of the "impact rule," the patient's family member could maintain an NIED action in the capacity of a bystander who witnesses or observes the negligent infliction of tortious injury upon their family member.³⁸⁶

For example, in *O'Connell v. Bridgeport Hospital*, the patient had authorized his wife to effectuate his wishes regarding the withholding and removal of life support.³⁸⁷ But hospital providers removed the patient's life support without notifying the wife or obtaining her consent.³⁸⁸ They should have, the wife alleged, known that those actions created an unreasonable risk of causing emotional distress.³⁸⁹ The Connecticut Superior Court ruled that the wife adequately stated a claim for negligent infliction of emotional distress.³⁹⁰

6. *Breach of Contract*

Breach of contract claims are not commonly brought against health care providers. "Considering the uncertainties of medical science and the variations in the physical and psychological conditions of individual patients, doctors can seldom in good faith promise specific results."³⁹¹ But they sometimes do make such promises, for example, a guarantee to make a patient's injured hand a "one hundred percent good hand."³⁹² And those promises can support a breach of contract action.³⁹³

³⁸⁵ See, e.g., *Ess v. Eskaton Props.*, 118 Cal. Rptr. 2d 240 (Cal. Ct. App. 2002).

³⁸⁶ See, e.g., *Thing v. La Chusa*, 771 P.2d 814 (Cal. 1989); *Alexander v. Scheid*, 726 N.E.2d 272, 283 (Ind. 2000); *Groves v. Taylor*, 729 N.E.2d 569, 572 (Ind. 2000) (holding that "there may well be circumstances where, while the plaintiff does not sustain a direct impact, the plaintiff is sufficiently directly involved in the incident giving rise to the emotional trauma that we are able to distinguish legitimate claims from the mere spurious"); *Rideout v. Hershey Med. Ctr.*, 30 Pa. D. & C.4th 57 (1995).

³⁸⁷ *O'Connell v. Bridgeport Hospital*, No. CV 990362525, 2000 WL 157814, at *1 (Conn. Super. Ct. Jan. 27, 2000).

³⁸⁸ *Id.*

³⁸⁹ *Id.*

³⁹⁰ *Id.*; see also *Hallada v. Lakeland Reg. Med. Ctr.*, No. 2103CA-002054 (Polk Cty. Cir. Ct., Fla. Apr. 1, 2013) (Complaint) (asserting claim for NIED for failing to record DNR order).

³⁹¹ *Sullivan v. O'Connor*, 296 N.E.2d 183, 186 (Mass. 1973). The court upheld a jury verdict for breach of contract where defendant promised to "perform plastic surgery on [plaintiff's] nose and thereby to enhance her beauty and improve her appearance. *Id.* at 184.

³⁹² *Hawkins v. McGee*, 146 A. 641, 643 (N.H. 1929); see also *Murphy v. Implicito*, 920 A.2d 678, 682-83 (N.J. Super. Ct. App. Div. 2007) (clinician promised not to use cadaver bone in back surgery).

³⁹³ *Murphy*, 920 A.2d at 689

In two recent cases, plaintiffs successfully brought breach of contract actions against clinicians who administered unwanted treatment. In *Russell v. Murphy*, an anesthesiologist administered a sedative despite both the patients' specific request for a local anesthetic and the anesthesiologist's representation that no sedative would be used.³⁹⁴ Similarly, in *Kaplan v. Mayo Clinic*, a surgeon promised not to perform a Whipple procedure until after first performing an inter-operative biopsy to confirm the pancreatic cancer diagnosis.³⁹⁵ But the agreed biopsy was never performed.³⁹⁶ It would have shown that the patient was cancer-free and did not need the Whipple.³⁹⁷

But perhaps the most notable breach of contract case for unwanted treatment is *Schieble v. Joseph L. Morse Geriatric Center*.³⁹⁸ In 1992, when she moved into a Florida nursing home at age 89, Madeline Neumann signed an advance directive instructing providers not to revive her if she collapsed.³⁹⁹ Three years later, on October 17, 1995, a nurse at the Joseph L. Morse Geriatric Center found Ms. Neumann unresponsive on the floor of her room.⁴⁰⁰ Despite Ms. Neumann's written instructions, the nurse summoned paramedics who attempted to revive Ms. Neumann and transported her to the hospital.⁴⁰¹ Ms. Neumann ended up intubated and restrained.⁴⁰² This was precisely the situation that she had hoped to avoid through her advance directive.⁴⁰³ At the family's request, hospital clinicians disconnected life support a few days later.⁴⁰⁴ The jury awarded \$150,000 on the breach of contract claim.⁴⁰⁵ The theory was that the advance directive was incorporated into the resident's nursing home contract.⁴⁰⁶

³⁹⁴ *Russell v. Murphy*, 86 S.W.3d 745 (Tex. Ct. App. 2002).

³⁹⁵ *Kaplan v. Mayo Clinic*, 653 F.3d 720 (8th Cir. 2011).

³⁹⁶ *Id.* at 727.

³⁹⁷ *Id.* at 728.

³⁹⁸ *Scheible v. Joseph L. Morse Geriatric Ctr*, 988 So. 2d 1130 (Fla. Dist. Ct. App. 2008); *see also* *Harvey v. Strickland*, 566 S.E.2d 529 (S.C. 2002) (reversing summary judgment where physician told patient that it "wouldn't be necessary for the blood transfusion"); *DiGeronimo v. Fuchs*, 927 N.Y.S.2d 904, 910 (N.Y. App. Div. 2011) (suggesting that Jehovah Witness plaintiff should have plead breach of contract).

³⁹⁹ *Scheible*, 988 So. 2d at 1131.

⁴⁰⁰ *Id.* at 1131-32

⁴⁰¹ *Id.*

⁴⁰² *Id.*

⁴⁰³ *Id.*

⁴⁰⁴ *Scheible*, 988 So. 2d at 1132.

⁴⁰⁵ *Id.*

⁴⁰⁶ *Id.* at 1133.

7. *Healthcare Decisions Acts*

Every state has a health care decisions act that protects patients' current and prospective autonomy by providing for advance directives, healthcare agents, and default surrogates.⁴⁰⁷ Clinicians must ordinarily comply with decisions and instructions made through these mechanisms. Intentionally violating this obligation subjects the provider to \$2,500 or actual damages, whichever is greater, plus reasonable attorney's fees.⁴⁰⁸ Several courts have specifically noted the availability of a statutory cause of action for unwanted life-sustaining treatment.⁴⁰⁹

Furthermore, even when a state health care decisions act fails to expressly provide for a cause of action, the statute can probably still be used to establish negligence per se.⁴¹⁰ When a statute provides that under certain circumstances particular acts shall or shall not be done, it may be interpreted as fixing a standard of care from which it is negligence to deviate.⁴¹¹ "Consequently, a violation of the statute may be

⁴⁰⁷ See Castillo et al., *supra* note 68; MEISEL & CERMINARA, *supra* note 25; *Resources & Research*, ABA COMMISSION ON LAW AND AGING, http://www.americanbar.org/groups/law_aging/resources.html (last visited Apr. 30, 2013). A handful of states do not statutorily authorize default surrogates.

⁴⁰⁸ *Id.*; CAL. PROB. CODE § 4742(a) (2009). Furthermore, the specified damages are "cumulative and not exclusive of any other remedies provided by law." *Id.* § 4742(c); see also MISS. CODE ANN. § 41-41-221(1) (2007) ("A health-care provider or institution that intentionally violates [this act] is subject to liability to the aggrieved individual for damages of . . . \$500.00 or actual damages resulting from the violation, whichever is greater, plus reasonable attorney's fees."); N.M. STAT. ANN. § 24-7A-10(A) (2006) (mandating \$5,000 or actual damages, plus reasonable attorney fees); 20 PA. CONS. STAT. § 5608(a) (2010) ("Any person who without reasonable cause fails to comply with [an agent's] instructions shall be subject to civil liability for any damages resulting from noncompliance."); WYO. STAT. ANN. § 35-22-411(a) (mandating \$500 or actual damages, plus reasonable attorney's fees).

⁴⁰⁹ See, e.g., *Ficke v. Evangelical Health Sys.*, 674 N.E.2d 888, 889 (Ill. App. Ct. 1996) (discussing cause of action under Illinois Health Care Surrogate Act); *Taylor v. Muncie Med. Investors*, 727 N.E.2d 466, 471 (Ind. Ct. App. 2000) (concerning an action brought for violation of the Illinois Health Care Consent Act among other causes of action).

⁴¹⁰ See, e.g., *Maresca v. Mancall*, No. CIV.A. 01-5355, 2003 WL 21652170, at *5 (E.D. Pa. June 20, 2003). "[T]he absence of a private right of action in a statutory scheme does not necessarily preclude the statute's use as the basis of a claim of negligence per se." *Id.*; *McCain v. Beverly Health & Rehab. Serv.*, No. CIV.A. 02-657, 2002 WL 1565526, at *1 (E.D. Pa. July 15, 2002). "[T]he lack of a private cause of action is not enough to preclude the use of the relevant policies expressed in . . . statutes and regulations." *Id.*

⁴¹¹ *Cook Uithoven v. Spinnaker's of Rivergate, Inc.*, 878 S.W.2d 934, 937 (Tenn. 1994).

In order to establish negligence per se, it must be shown that the statute violated was designed to impose a duty or prohibit an act for the benefit of a

deemed to be negligence per se.”⁴¹²

To “borrow” the statute to set the standard of care normally requires establishing: (1) that the plaintiff belongs to the class of persons the statute was designed to protect; and (2) that the plaintiff’s injuries were the type that the statute was designed to prevent.⁴¹³ Patients have been able to satisfy both of these conditions. In related actions against healthcare facilities, patients have proved negligence per se by offering proof that the provider violated federal or state patient safety regulations.⁴¹⁴ State health care decisions acts are similarly appropriate bases for negligence per se actions. They were specifically designed to protect patients against unwanted life-sustaining treatment.

8. POLST Statutes

Just as healthcare decisions acts authorize statutory damages and causes of action for violating advance directives, POLST statutes also authorize private rights of action, though usually not as directly. North Carolina, for example, provides that a clinician will not be subject to civil liability for failure to follow POLST only if “the provider had no actual knowledge of [its] existence.”⁴¹⁵

9. Section 1983

More than 1,100 hospitals, 22% of all hospitals in the United States, are operated by a municipal, state, or federal government.⁴¹⁶ Therefore, the administration of unwanted treatment in such a facility constitutes state action. Accordingly, some plaintiffs have brought actions under Section 1983⁴¹⁷ or related statutes.⁴¹⁸ Section 1983

person or the public. It must also be established that the injured party was within the class of persons that the statute was meant to protect.

Id. (citations omitted).

⁴¹² *Id.* at 937.

⁴¹³ See *Whaley v Perkins*, 197 S.W.3d 665, 673 (Tenn. 2006).

⁴¹⁴ See, e.g., *French v. Stratford House*, 333 S.W.3d 546, 550 (Tenn. 2011) (holding proof of violations of the statute can be offered in support of negligence claims); *McCain*, No. CIV. A. 02-657, 2002 WL 1565526 at *554 (finding statutes violated were held to be able to form the basis of a claim for negligence per se); *McLain v. Mariner Health Care, Inc.*, 631 S.E.2d 435 (Ga. Ct. App. 2006) (noting violations of the state and federal statutes were sufficient to show negligence per se).

⁴¹⁵ N.C. GEN. STAT. § 90-21.17 (2011).

⁴¹⁶ Taressa Fraze et al., *Public Hospitals in the United States*, AHRQ STATISTICAL BRIEF #95 (Sept. 2010), <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb95.pdf>.

⁴¹⁷ See, e.g., *Williams v. Wilzack*, 573 A.2d 809 (Md. 1990) (describing psychiatric patient forced to

provides that:

Every person who under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory . . . subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law. . . .⁴¹⁹

So, the plaintiffs must establish that, under the color of state law, the defendant: (1) subjected them; (2) to a deprivation of rights; (3) guaranteed by the Constitution or laws of the United States.⁴²⁰ The federally protected rights that plaintiffs have claimed state actors deprived them of, by administering unwanted life-sustaining treatment, have included: (1) the Constitutional right to privacy and self-determination; (2) procedural due process; (3) free exercise of religion; (4) equal protection; (5) search and seizure; (6) cruel and unusual punishment; and (7) the contract clause.⁴²¹

10. False Claims Act

The False Claims Act prohibits the submission of false or fraudulent claims to the federal government.⁴²² When health care providers administer unwanted life-

take anti-psychotic medication); *accord* Granato v. City & Cty. of Denver, No. 11-CV-00304-MSK-BNB, 2011 WL 3820730 (D. Colo. Aug. 30, 2011); Jarvis v. Levine, 418 N.W.2d 139 (Minn. 1988); Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986). Most of these cases concerning life-sustaining treatment have been unsuccessful. *See, e.g.*, Sama v. Hannigan, No. 10-40835 (5th Cir. 2012); Klavan v. Crozer-Chester Med. Ctr., 60 F. Supp. 2d 436, 440 (E.D. Pa. 1999) (dismissing case where plaintiff failed to show defendants were state actors); Ross v. Hilltop Rehab. Hosp., 676 F. Supp. 1528 (D. Colo. 1987) (dismissing action on grounds that hospital and physicians were private not government, actors); Foster v. Tourtellotte, 704 F.2d 1109 (9th Cir. 1983), *superseded by statute as stated in*, Oliveira v. Bowen, 664 F. Supp. 1320 (N.D. Cal. 1986). *But see* McKenzie v. Doctor's Hosp. of Hollywood, Inc., 765 F. Supp. 1504 (S.D. Fla. 1991) (suggesting patient would have claim for violation of freedom of religion where clinicians acted pursuant to state court order).

⁴¹⁸ *See, e.g.*, Bartling v. Glendale Adventist Med. Ctr., 229 Cal. Rptr. 360, 364 (Cal. Ct. App. 1986). The plaintiff in this case argued that the medical center engaged in a conspiracy to deprive him of his Constitutional rights in violation of Section 1985(3) of the Federal Civil Rights Act. *Id.*

⁴¹⁹ 42 U.S.C. § 1983 (2006).

⁴²⁰ Parratt v. Taylor, 451 U.S. 527, 535 (1981), *overruled by* Daniels v Williams, 106 S. Ct. 662 (1986).

⁴²¹ *See* MEISEL AND CERMINARA, *supra* note 25, at § 11.09[A][1].

⁴²² 31 U.S.C. § 3729 (2006).

sustaining treatment and then bill for it, they are likely in violation of the False Claims Act for at least three separate reasons.⁴²³

First, when they submit a claim for reimbursement, providers implicitly certify that they have complied with the conditions of payment for Medicare, including all applicable federal laws and regulations.⁴²⁴ But such a certification will be false in the case of unwanted treatment, because federal regulations require participating facilities to allow patients to “refuse treatment.”⁴²⁵

Second, Medicare requires that reimbursed treatments be “medically necessary.”⁴²⁶ When submitting a claim for reimbursement, the provider must “certify that the services shown on this form were medically indicated and necessary for the health of the patient. . . .”⁴²⁷ “When a competent and informed patient or surrogate expressly declines treatment, such treatment cannot be considered ‘medically necessary.’”⁴²⁸

Third, Medicare does not reimburse for “worthless services.”⁴²⁹ A worthless service “has no medical value” or is “so deficient that for all practical purposes it is the

⁴²³ JEFFERY J. SNELL, A.B.A. COMM’N ON L. AND AGING, REPORT TO THE HOUSE OF DELEGATES: RESOLUTION 106B (Aug. 2011) (recommendations were eventually withdrawn).

⁴²⁴ *Mikes v. Straus*, 274 F.3d 687, 700 (2d Cir. 2001); *U.S. v. Rogan*, 459 F. Supp. 2d 692, 717-18 (N.D. Ill. 2006); *U.S. ex rel. Aranda v. Community Psychiatric Ctrs.*, 945 F. Supp. 1485, 1487-88 (W.D. Okla. 1996).

⁴²⁵ 42 C.F.R. § 482.13 (2012).

⁴²⁶ 42 U.S.C. § 3120c-5(a)(1) (2006).

⁴²⁷ CTRS FOR MEDICARE & MEDICAID SERV, HEALTH INSURANCE CLAIM FORM 1500 (1990), *available at*

http://smchealth.org/sites/default/files/docs/BHS/Health_insurance_claim.pdf; *see also* 42 C.F.R. § 424.32(a)(1) (2012) (stating that such a certification is a prerequisite to Medicare reimbursement).

⁴²⁸ SNELL, *supra* note 423, at 4.

⁴²⁹ *Mikes*, 274 F.3d at 702-03; *U.S. v. Wachter*, No. 4:05CR667SNL, 2006 WL 2460790, at *11 (E.D. Mo. Aug. 23, 2006). Stating an False Claims Act claim in indictment was legally sufficient on worthless service theory, which “could include services that were so deficient that they were of no utility to the [nursing home] resident, or were totally undesirable.” *Id.*; *see also* *U.S. v. NHC Health Care Corp.*, 163 F. Supp. 2d 1051, 1056 (W.D. Mo. 2001) (holding a jury could conclude that defendant nursing home failed to “perform the minimum necessary care activities required to promote the patient’s quality of life”); *U.S. v. Villaspring Health Care Ctr., Inc.*, No. 3:11-43-DCR, 2011 WL 6337455 (E.D. Ky. Dec. 19, 2011) (similar); *U.S. v. Momence Meadows Nursing Ctr.*, No. 2:04-CV-02289 (C.D. Ill. Feb. 8, 2011) (\$28 million verdict for worthless services and false certification).

equivalent of no performance at all.”⁴³⁰ Unwanted medical treatment is arguably a “worthless service” because the patient or surrogate has already determined that it is “of no medical value” to the patient.

A critically important part of the False Claims Act is its *qui tam* provision.⁴³¹ This provision is designed to encourage citizens with knowledge of fraud against the government to come forward by authorizing them to file a civil suit in the name of the government, and by rewarding them with a percentage of the recovery. Some organizations are educating, encouraging, and empowering individuals to fight healthcare fraud related to unwanted life-sustaining treatment.⁴³²

11. Other Costs of Liability

As demonstrated in the last ten subsections, plaintiffs have been increasingly able to establish civil liability under tort, contract, and statutory causes of action. Moreover, they have been able to obtain not only compensatory damages but they have been able to impose three other types of financial penalties: (1) attorney’s fees;⁴³³ (2) punitive damages;⁴³⁴ and nonpayment for rendered medical services.⁴³⁵ Many health

⁴³⁰ *Mikes*, 274 F.3d at 702.

⁴³¹ 31 U.S.C. § 3130(b)-(d).

⁴³² Compassion & Choices, *Unwanted Medical Treatment: Toolkit for Compassion & Choices Advocates* (Feb. 27, 2013), <http://community.compassionandchoices.org/document.doc?id=1283>; *Do No Harm: When Healthcare Goes too Far*, COMPASSION & CHOICES MAG. (Spring 2013), at 12-18. CHOOSING WISELY, *Five Things Physicians and Patients Should Question* (2012), <http://www.choosingwisely.org/doctor-patient-lists/>; American College of Physicians, *High Value Care* (2013), <http://hvc.acponline.org>.

⁴³³ See *Gray v. Romeo*, 709 F. Supp. 325 (D.R.I. 1989) (ordering defendants to pay plaintiff \$38,495.95 in attorney fees); *McMahon v. Lopez*, 245 Cal. Rptr. 172 (Cal. Ct. App. 1988); *Bouvia v. County of LA*, 241 Cal. Rptr. 239 (Cal. Ct. App. 1987) (remanding for fees); *In re Carothers*, No. 89PR66 (Mesa Cty. Dist. Ct. Feb. 15, 1989); *Hoffmeister v. Coler*, 544 So. 2d 1067 (Fla. Dist. Ct. App. 1989).

⁴³⁴ See, e.g., *Leach*, 469 N.E.2d at 1055. Punitive or exemplary damages are appropriate when the clinician’s conduct is willful or malicious. See generally *DOBBS*, *supra* note 288, § 381, at 1062; see, e.g., *id.* at 648-49 (“Courts have considered the negligence of a physician or surgeon to be so obvious or gross that a jury should be allowed to find negligence ... because gross and obvious negligence is an independent exception”); *Duncan v. Scottsdale Med. Imaging Ltd.*, 70 P.3d 435 (Ariz. 2003) (finding a patient who forbids all sedatives except Demerol is not consenting to some other sedative); *Rains v. Superior Ct.*, 198 Cal. Rptr. 249 (Cal. Ct. App. 1984).

⁴³⁵ Marshall Kapp, *Enforcing Patient Preferences: Linking Payment for Medical Care to Informed Consent*, 261 JAMA 1935, 1936 (1989) (“In the realm of reimbursement . . . medical services should be considered as any other economic commodity - to be paid for only when voluntarily, knowingly, and competently purchased.”); Gasner, *supra* note 12, at 514 (“Permitting payment for unwanted

care decisions acts authorize attorney's fees for prevailing parties.⁴³⁶ Intentional torts like battery and IIED usually also support punitive damages.⁴³⁷ And providers are often unable to get reimbursed for administering unwanted treatment.⁴³⁸

B. Mitigation of Legal Obstacles

Not only have plaintiffs been able to establish the civil liability of clinicians administering unwanted life-sustaining treatment, but also the five "perceived" obstacles to establishing such liability are not nearly as significant as they are salient.⁴³⁹ First, while the "wrongful living" cause of action has been widely rejected, it is superfluous and unnecessary. Second, while private claims under the PSDA have been rejected, they too are unnecessary, given alternate common law and statutory remedies. Third, while the emergency situation implies an exception to the consent requirement, that exception is conditional and limited. Fourth, safe harbor immunity is tightly circumscribed. Fifth, conscience clause immunity is similarly confined.

1. A "Wrongful Living" Cause of Action is Unnecessary.

The rejection of a "wrongful living" cause of action has been described as a major obstacle to clinician accountability.⁴⁴⁰ But its non-recognition is actually largely

treatment provides a serious disincentive to honor patient choice."); Pedrick, *supra* note 227, at 399 (arguing for "fiscal persuasion" to get providers to honor instructions).

⁴³⁶ See, e.g., ME. REV. STAT. § 5-810(b).

⁴³⁷ LINDA L. SCHLUETER, PUNITIVE DAMAGES ch. 9 (6th ed. LexisNexis 2010).

⁴³⁸ See, e.g., Rockville Gen. Hosp. v. Wirzulis, No. CV-000072868 (Conn. Super. Ct. Feb. 28, 2003) (noting patient not obligated to pay for the cost of an intensive care room); Grace Plaza of Great Neck v. Elbaum, 588 N.Y.S.2d 853 (App. Div. 1992) (holding that patients who do not consent are not liable for any treatment provided in contravention of their wishes but further holding family could not refuse to pay for care rendered while a court determined if the patient had actually refused the treatment); Gragg v. Calenda, 696 N.E.2d 1282, 1285 (Ill. App. Ct. 1998). But see, e.g., First Healthcare Corp. v. Rettinger, 467 S.E.2d 243, 244 (N.C. 1996) (allowing payment because statutory requirements had not been satisfied); Leach v. Shapiro, 469 N.E.2d 1047, 1053-55 (Ohio App. Ct. 1984); Novak v. Cobb Cty. Kennestone Hosp. Auth., 74 F.3d 1173, 1176-77 (11th Cir. Feb. 14, 1996) (describing how a hospital got court order to perform treatment). Cf. Lawson v. Fleming, No. 10-CV-00900-BNB (D. Colo. June 10, 2010) (patient sued when providers attempted to collect for "unwanted and unauthorized medical treatment").

⁴³⁹ See *supra* Section IV.C.

⁴⁴⁰ See, e.g., Richard P. Dooling, *Damage Actions for Nonconsensual Life-Sustaining Medical Treatment*, 30 ST. LOUIS U. L.J. 895 (1986); A. Samuel Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625 (1986); Tricia Jonas Hackleman, *Violation of an Individual's Right to Die: The Need for a Wrongful Living Cause of Action*, 64 U. CIN. L. REV. 1355 (1996); William C. Knapp & Fred Hamilton, "Wrongful Living": Resuscitation as Tortious Interference

irrelevant. First, as the foregoing discussion illustrates, there are ample alternative theories of liability. There is no need for a new and separate “wrongful living” cause of action. So, in *Cronin v. Jamaica Hospital Medical Center*, the parties reached a settlement, even though the court affirmed summary judgment dismissing the complaint on the ground that the plaintiff was asserting a claim for “wrongful living” and that no such cause of action could be maintained.⁴⁴¹

Second, even to the extent that “wrongful living” is considered just a damages concept,⁴⁴² the impact of its rejection is limited. Even if a plaintiff cannot recover for the prolongation of life itself, she can still recover for pain and suffering from the treatment itself and for the affront to her autonomy.⁴⁴³ In other words, she does not claim damages for the pain and suffering caused by being alive, but rather for the pain and suffering caused by being treated against her beliefs and values.⁴⁴⁴

Furthermore, it is likely that today’s courts would recognize a wrongful living cause of action. The earlier rejections were due to courts’ reluctance to award damages where the withdrawing of life-sustaining treatment was not yet well-established.⁴⁴⁵ But end-of-life jurisprudence has evolved significantly in that regard.

with a Patient’s Right to Give Informed Refusal, 19 N. KY. L. REV. 253 (1992); Steven L. Addlestone, Note, *Liability for Improper Maintenance of Life Support: Balancing Patient and Physician Autonomy*, 46 VAND. L. REV. 1255 (1993).

⁴⁴¹ *Cronin v. Jamaica Hosp. Med. Ctr.*, 60 A.D.3d 803, 804 (N.Y. App. Div. 2009); Lisa Corneau, Attorney, Appellate Counsel, *Remarks at the Freedom of Choice at the End of Life Symposium* (Nov. 16, 2012), available at http://www.nyls.edu/centers/harlan_scholar_centers/justice_action_center/annual_conferences/end_of_life.

⁴⁴² See MEISEL & CERMINARA, *supra* note 25, at § 11.03[B][4][b]; Lynch et al., *supra* note 37, at 141-42.

⁴⁴³ See DOBBS, *supra* note 288, § 42, at 79 (noting that “the invasion of plaintiff’s rights is regarded as a harm in itself and subject to an award of damages”); *Self v. Milyard*, No. 11-CV-00813-RBJ-CBS, 2012 WL 1602104 (D. Colo. May 7, 2012) (suing for pain and discomfort while going through an extubation process contrary to a DNR order); *Murphy v. Implicito*, 920 A.2d 678 (N.J. Super. A.D. 2007). However, courts are less willing to permit recovery for living expenses. *Cf. Emerson v. Magendantz*, 689 A.2d 409, 411-14 (R.I. 1997).

⁴⁴⁴ See Sabine Michalowski, *Trial and Error at the End of Life—No Harm Done?*, 27 OXFORD J. LEGAL STUDIES 257, 268, 270 (2007).

⁴⁴⁵ See, e.g., DAVID ORENTLICHER ET AL., *BIOETHICS AND PUBLIC HEALTH LAW* 298-99 (2d ed. 2008); *Bartling v. Glendale Adventist Med. Ctr.*, 229 Cal. Rptr. 360 (Cal. App. 1986). The court in *Bartling* affirmed the dismissal of claims for battery, breach of fiduciary duty, intentional infliction of emotional distress, and of violations of constitutional and civil rights; because state of the law was such that providers’ actions did not rise to the level of “conscious” disregard of patient’s rights. *Id.* at 364.

The concept of “wrongful life” was deemed problematic, because “life” was presumed to be a positive thing. But the whole point for some seriously ill patients is that they do not see their own lives in that way.⁴⁴⁶ For these patients, the unwanted administration of life-sustaining treatment is tantamount to medical torture. Courts have been increasingly recognizing that many individuals find themselves in a condition they find abhorrent. For them, even life-saving medical attention is harmful.⁴⁴⁷ Even the right-to-die cases of the 1980s and 1990s “evidence some concession by courts that life may not always be preferable to nonexistence.”⁴⁴⁸ With the development of not just right-to-die, but also aid-in-dying jurisprudence, that proposition now is far more settled.⁴⁴⁹

2. *Private Claims under the PSDA are Unnecessary*

Like the rejection of a “wrongful living” cause of action, the rejection of a cause of action under the PSDA may send a symbolic message that administering unwanted life-sustaining treatment is not a legal wrong. But the availability of a remedy under this statute, like the availability of a “wrongful living” cause of action is actually irrelevant. The PSDA only enforced underlying substantive rights under state law. Since state law provides its own remedies and enforcement mechanisms, a cause of action under the PSDA is unnecessary.

3. *The Emergency Exception is Limited*

Some courts have permitted a rather expansive use of the emergency exception to find implied consent for the administration of life-sustaining treatment even when actual consent was specifically denied.⁴⁵⁰ But this hardly means that the emergency exception is tantamount to a “blank check” for clinicians to administer whatever treatment they want, whenever they deem it appropriate, notwithstanding the absence of patient or surrogate consent.

⁴⁴⁶ See Pope & Anderson, *supra* note 20, at 368-75.

⁴⁴⁷ *Bartling*, 229 Cal. Rptr. at 362 (quoting the patient’s description of “artificial existence” as “unbearable, degrading and dehumanizing”). “Certainly life is valuable;” however, for those with terminal illnesses, “the preference . . . may be to hasten death so that death can be on an individual’s terms.” *Id.* at 375.

⁴⁴⁸ Alan J. Belsky, *Injury as a Matter of Law: Is This the Answer to the Wrongful Life Dilemma?*, 22 U. BALT. L. REV. 185, 223 (1993); see also Strasser, *supra* note 243, at 1038-41; Peters, *supra* note 11, at 691.

⁴⁴⁹ See, e.g., *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009); *Carter v. Canada* (Attorney General), 2012 BCSC 886.

⁴⁵⁰ See *supra* notes 287-94 and accompanying text.

The emergency exception requires that under the circumstances a reasonable person would consent, and the probabilities are that the patient would consent.⁴⁵¹ The physician must have “no reason to think the plaintiff would refuse consent.”⁴⁵² This requirement is not satisfied, if the clinician knows that the patient either actually rejected or would reject the treatment.

For example, an Illinois appellate court recently held that the existence of medical emergency was irrelevant where patient had “clearly refused [a particular treatment] at an earlier time.”⁴⁵³ And in *Malette v. Shulman*, the court held that the emergency exception would have authorized the physician to administer blood transfusions only had there been “no Jehovah’s Witness card.”⁴⁵⁴

Simply put, the emergency exception is inapplicable in the situation in which the patient has expressly refused treatment.⁴⁵⁵ “If the patient, while competent, has reliably expressed her opposition to a particular medical procedure, her wishes are not to be overridden when she falls unconscious and death is imminent.”⁴⁵⁶ Otherwise, “[c]arried to its extreme . . . the doctrine of implied consent could effectively nullify those privacy rights” recognized in statutory and common law.⁴⁵⁷

4. *Safe Harbor Immunity is Limited*

Many states grant legal immunity to health care providers who refuse to comply with patients’ treatment requests.⁴⁵⁸ But the conferral of this immunity is almost always conditional.⁴⁵⁹ In California, for example, a health care provider that declines to comply with an individual health care instruction or health care decision must “make all

⁴⁵¹ PROSSER, *supra* note 349, at § 18, at 117.

⁴⁵² DOBBS, *supra* note 288, § 106, at 247; *id.* (“The emergency rule is not intended to permit providers to overcome or avoid confronting the patient’s wishes”).

⁴⁵³ *Sekerez v. Rush Univ. Med. Ctr.*, 954 N.E.2d 383, 396 (Ill. App. 2011).

⁴⁵⁴ *Malette v. Shulman*, 67 D.L.R. 4th 321 (Ont. C.A. 1990).

⁴⁵⁵ *Curtis v. Jaskey*, 759 N.E.2d 962, 966-67 (Ill. App. Ct. 2001); *Rodriguez v. Pino*, 634 So. 2d 681, 683 (Fla. Dist. Ct. App. 1994); *Estate of Leach v. Shapiro*, 469 N.E.2d 1047, 1053 (Ohio Ct. App. 1984) (“where the parties contract expressly with regard to a particular procedure, an implied agreement cannot thereafter arise when the express agreement directly controverts the inclusion of any such implication.”); Hegland, *supra* note 170, at 865 (“This rationale, however, cannot be applied where it is clear that the patient’s true desire is to refuse consent”).

⁴⁵⁶ DOBBS, *supra* note 288, § 106, at 247.

⁴⁵⁷ *Leach*, 469 N.E.2d at 1053.

⁴⁵⁸ See *supra* notes 286-88 and accompanying text.

⁴⁵⁹ See Thaddeus M. Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 56-58 (2007).

reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision;” and, the provider must “provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished.”⁴⁶⁰

In *Cardoza v. USC University Hospital*, the California Court of Appeal held that there are definite limits to the scope of safe harbor immunity.⁴⁶¹ Health care providers complied with decisions of an appointed health care agent, a son of the patient, to continue aggressive interventions for his mother.⁴⁶² But the agent’s sister, and patient’s daughter, brought a lawsuit alleging that providers failed to comply with her mother’s advance directive.⁴⁶³ Since the surrogate had no authority to contravene instructions and preferences memorialized in the advance directive, the court held that the hospital could not have complied with the surrogate’s decisions “in good faith.”⁴⁶⁴ Therefore, the court held that the hospital was not entitled to immunity.⁴⁶⁵

Similarly, in *Malette v. Shulman*, the patient had a Jehovah’s Witness card that said “No Blood Transfusion.”⁴⁶⁶ The physician was “not satisfied” that the card expressed the patient’s current instructions.⁴⁶⁷ He did not know:

whether she might have changed her religious beliefs before the accident; whether the card may have been signed because of family or peer pressure; whether at the time she signed the card she was fully informed of the risks of refusal of blood transfusions; or whether, if conscious, she might have changed her mind.⁴⁶⁸

But these were rather abstract concerns. The physician had no specific grounds to doubt that the card “constituted a valid statement of the patient’s wishes.”⁴⁶⁹ Accordingly, the court held that the card “had the effect of validly restricting the treatment that could be provided.”⁴⁷⁰

⁴⁶⁰ CAL. PROB. CODE §§ 4736, 4740(d) (West 2009).

⁴⁶¹ *Cardoza v. USC Univ. Hosp.*, No. B195092, 2008 WL 3413312, *14-15 (Cal. Ct. App. 2008).

⁴⁶² *Id.* at *1.

⁴⁶³ *Id.*

⁴⁶⁴ *Id.* at *5.

⁴⁶⁵ *Id.*

⁴⁶⁶ *Malette v. Shulman*, 72 O.R.2d 417 (Ont. Ct. App.1990).

⁴⁶⁷ *Id.*

⁴⁶⁸ *Id.*

⁴⁶⁹ *Id.*

⁴⁷⁰ *Id.*; see also *Harvey v. Strickland*, 566 S.E.2d 529, 533-34 (S.C. 2002). This case holds that

5. *Conscience Clauses are Limited*

Just as the scope of safe harbor immunity for professionally grounded refusals is limited, so is the scope of immunity for personal, conscience-based objections.⁴⁷¹ For example, in *Folley v. United Surgical Partners*,⁴⁷² a medical facility required all its patients to sign a consent form acknowledging that the center will “not honor a request for ‘Do Not Resuscitate’ status and/or Advance Directives or Living Wills.” The surgery center claimed that its refusal to honor advance directives was allowable under the law’s “reason of conscience” exemption.⁴⁷³

But United Surgical Partners never produced any policy or mission statement demonstrating that a commitment to religious ideals informed their refusal to honor living wills.⁴⁷⁴ Indeed, it was odd that they rejected all advance directives, even those that would require doctors to try to prolong life.⁴⁷⁵ Furthermore, the surgery center failed to make efforts to transfer its patients to another facility willing to comply with their advance directives.⁴⁷⁶ The ACLU sued the facility for violating the conditions of New Mexico Health Care’s conscience safe harbor.⁴⁷⁷ Recognizing that it lacked protection, United Surgical Partners quickly changed its policy.⁴⁷⁸

Another example of the limitations and qualifications typical of conscience clauses is Iowa’s 2012 POLST statute, which provides that a health care provider “unwilling to comply with an executed POST form based on policy, religious beliefs, or moral convictions” shall nevertheless “take all reasonable steps to transfer the patient to another health care provider, hospital, or health care facility.”⁴⁷⁹

physician should have neither sought, nor accepted, consent from the patient’s mother where the patient’s wishes were clear. *Id.*

⁴⁷¹ *Conscience Clauses and Conscientious Refusal*, *supra* note 206, at 163.

⁴⁷² Brief for Plaintiff at 3, *Folley v. United Surgical Partners et al.*, (2005), *available at* <http://www.aclu.org/files/FilesPDFs/ACF2E79.pdf>.

⁴⁷³ *Id.*

⁴⁷⁴ *Id.*

⁴⁷⁵ Press Release, American Civil Liberties Union, ACLU of New Mexico Defends Patient’s End-of-Life Wishes (June 9, 2005), *available at* <http://www.aclu.org/privacy/medical/15343prs20050609.html>.

⁴⁷⁶ *Id.*

⁴⁷⁷ N.M. STAT. ANN. § 24-7A-7E (1997) (current version at § 24-7A-7E (2009)).

⁴⁷⁸ Press Release, American Civil Liberties Union, ACLU of New Mexico Defends Patient’s End-of-Life Wishes (June 9, 2005), *available at* <http://www.aclu.org/privacy/medical/15343prs20050609.html>.

⁴⁷⁹ IOWA CODE ANN. § 144D.3(5) (2012); *see also* IDAHO CODE ANN. § 39-4513(2) (2012). This statute permits a provider to:

C. Administrative Sanctions

While litigation is one form of health care regulation, it is complemented by others.⁴⁸⁰ Most relevant here are: (1) medical board discipline; and (2) facility inspections and sanctions.⁴⁸¹

1. Medical Board Discipline

Every state has a state medical board charged with assuring that the physicians practicing within the state have the requisite qualifications and skills to safely provide health care services to the public.⁴⁸² Medical boards do this by performing three core functions. First, they determine which physicians meet the standards of the state to legally practice medicine. Second, they establish standards for appropriate physician practice. Third, medical boards remove incompetent and otherwise unfit physicians. The first two functions pertain to gatekeeping. In this section, I will focus on the third function: discipline.

State health care decisions acts specifically authorize medical board discipline for failing to honor patient treatment choices. For example, New Jersey provides: “A health care professional who intentionally fails to act in accordance with the requirements of this act is subject to discipline for professional misconduct.”⁴⁸³

withdraw without incurring any civil or criminal liability provided the physician or other health care provider, before withdrawal of his or her participation, makes a good faith effort to assist the person in obtaining the services of another physician or other health care provider who is willing to provide care for the person in accordance with the person's expressed or documented wishes.

Id.

⁴⁸⁰ Thaddeus M. Pope, *The Topography and Geography of U.S. Health Care Regulation*, 38 J.L. MED. & ETHICS 427, 427-31 (2010) (examining the structure, coverage, supplements, underlying themes, and limitations of health care regulation in America).

⁴⁸¹ *Anderson v. St. Francis-St. George Hosp.*, 671 N.E.2d 225, 229 (Ohio 1996) (recognizing availability of “licensing sanctions”); Michalowski, *supra* note 444, at 280. This article notes that “[...]ability in tort is not the only way in which physicians can be encouraged to respect advance directives, as there is also the possibility of disciplinary sanctions in case of a violation of the patient’s declared wishes.” *Id.*

⁴⁸² See generally James N. Thompson & Lisa A. Robin, *State Medical Boards: Challenges for Regulation and Quality Enhancement of Medical Care*, 33 J. LEGAL MED. 93, 96 (2012).

⁴⁸³ N.J. STAT. ANN. § 26-2H-78(a); see also S.C. CODE ANN. § 44-77-100 (“A failure by a physician to effectuate the declaration of a terminal patient constitutes unprofessional conduct if the

Similarly, under New Jersey's new POLST statute: "A health care professional who intentionally fails to act in accordance with the requirements of this act is subject to discipline for professional misconduct."⁴⁸⁴

And those are not the only sources of professional license-based obligations to respect patient treatment refusals. State medical license codes often broadly reference patient autonomy rights. For example, the New Mexico medical code expressly incorporates the American Medical Association ("AMA") Code of Medical Ethics.⁴⁸⁵ This means that a breach of the AMA Code can constitute "unprofessional conduct" and grounds for discipline, including the denial, suspension or revocation of or the imposition of restrictions or conditions on a license.⁴⁸⁶

The AMA Code "requires that physicians respect the decision to forego life-sustaining treatment . . . not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration."⁴⁸⁷ It further provides: "advance directives stating patients' refusals of CPR should be honored whether patients are in or out of hospital. When patients refuse CPR, physicians should not permit their personal value judgments to obstruct implementation of the refusals."⁴⁸⁸

One notable enforcement action was brought against New York physician Mahmood Yoonessi, the clinician with whom story this article began.⁴⁸⁹ Recall that Dr. Yoonessi, a specialist in gynecologic oncology,⁴⁹⁰ performed an "extensive surgical procedure" on a 67-year-old patient with advanced ovarian cancer.⁴⁹¹ Unfortunately, the patient developed problems post-operatively necessitating blood transfusions, and lost decision-making capacity, at which point the patient's family determined that "enough was enough."⁴⁹² So, they authorized the entry of a DNR order and directed that the

physician fails or refuses to make reasonable efforts to effect the transfer of the patient to another physician who will effectuate the declaration").

⁴⁸⁴ N.J. STAT. ANN. § 26:2H-139(a). I was retained as an expert witness by a New Mexico hospital on this point. See *Bhandari v. VHA Southwest Comm. Health Corp.*, No. 1:09-CV-00932-JB-GBW (D.N.M. 2010) (Deposition).

⁴⁸⁵ N.M.A.C. § 16.10.8.9(A) ("The board adopts the ethical standards set forth in the latest published version of the 'code of medical ethics current opinions with annotations of the Council on Ethical and Judicial Affairs of the American Medical Association' . . .").

⁴⁸⁶ N.M. STAT. ANN. § 61-6B-9(B)(5).

⁴⁸⁷ AM. MED. ASS'N, CODE OF MEDICAL ETHICS Opinion 2.20.

⁴⁸⁸ *Id.* at Opinion 2.22.

⁴⁸⁹ See *supra* notes 1-7 and accompanying text.

⁴⁹⁰ *In re Yoonessi*, No. BPMC 02-188, 2002 WL 33840948 (N.Y.B.P.M.C. June 5, 2002).

⁴⁹¹ *Id.* at *15.

⁴⁹² *Id.* at *16.

patient receive no further transfusions.⁴⁹³

But Dr. Yoonessi “wanted to further aggressively treat the patient.”⁴⁹⁴ He said, “I don’t care what the family wants” and ordered blood anyway.⁴⁹⁵ Dr. Yoonessi told the family that “they were being like Jack Kevorkian, that if this was his mother he wouldn’t allow this to happen, and that they were playing God by not allowing their mother to have further treatment.”⁴⁹⁶

The New York Board of Professional Medical Conduct found that Dr. Yoonessi’s “inflammatory statements” were “most inappropriate” and a “severe deviation from acceptable standards of care.”⁴⁹⁷ The Board concluded that this conduct constituted “gross negligence and moral unfitness.”⁴⁹⁸

The Board also reviewed Dr. Yoonessi’s conduct with respect to two other patients on whom he attempted resuscitation despite their DNR status and found this was “an assault” and constituted “gross negligence and lack of proper consent.”⁴⁹⁹ It held: “Once the patient signs the DNR consent, the physician is obliged to follow the patient’s request.”⁵⁰⁰ “No physician has the right to cancel a DNR without patient consent.”⁵⁰¹

The Board concluded that Dr. Yoonessi “totally ignored his responsibility . . . to review the DNR order for his patient. . . . Assaulting a patient is reckless disregard for the patient’s rights.”⁵⁰² The Board further concluded that countermanding a DNR order requested by the patient is a “very significant deviation” that constitutes “gross negligence, lack of proper consent, and moral unfitness.”⁵⁰³

The case against Dr. Yoonessi also included other violations. But the Board was especially concerned with his violation of “the principle of patient control and

⁴⁹³ *Id.*

⁴⁹⁴ *Id.*

⁴⁹⁵ *Id.* at *18.

⁴⁹⁶ *Yoonessi*, 2002 WL 33840948 at *16 (N.Y.B.P.M.C. June 5, 2002).

⁴⁹⁷ *Id.* at *17.

⁴⁹⁸ *Id.*

⁴⁹⁹ *Id.* at *22-23.

⁵⁰⁰ *Id.* at *32.

⁵⁰¹ *Id.*

⁵⁰² *Yoonessi*, 2002 WL 33840948 at *23-24.

⁵⁰³ *Id.* at *32.

autonomy.”⁵⁰⁴ The Board observed: “Perhaps the most egregious violation is [Dr. Yoonessi’s] disregard of the wishes of the patient or their duly authorized surrogates concerning end of life decisions.”⁵⁰⁵ Accordingly, the Board revoked Dr. Yoonessi’s license to practice medicine.⁵⁰⁶

And Dr. Yoonessi’s legal troubles did not end there. A few weeks after the New York Board revoked Dr. Yoonessi’s license to practice in New York, the Medical Board of California revoked his California license.⁵⁰⁷ The California Board, persuaded by the New York Board’s finding that Dr. Yoonessi was “beyond rehabilitation,” concluded that he was not “safe to practice medicine in California.”⁵⁰⁸ Six years later, in 2008, the California Board denied Dr. Yoonessi’s petition for reinstatement.⁵⁰⁹

The case against Dr. Yoonessi is not unique. State medical boards have been more aggressively investigating and disciplining physicians.⁵¹⁰ Specifically, other physicians have similarly been disciplined by state medical boards for administering treatment without consent.⁵¹¹ Even if the board ultimately imposes no sanctions, physicians can be severely penalized simply as a consequence of the investigation.⁵¹² The collateral damages can be enormous.

For example, Albert Dworkin was eventually exonerated by the Delaware

⁵⁰⁴ *Id.* at *38.

⁵⁰⁵ *Id.*

⁵⁰⁶ *Id.* at *40-41.

⁵⁰⁷ *In re Yoonessi*, No. 16-2001-128690 (Med. Bd. Cal. Apr. 30, 2003).

⁵⁰⁸ *Id.*

⁵⁰⁹ *In re Yoonessi*, No. 20-2006-179832 (Med. Bd. Cal. Sept. 10, 2008).

⁵¹⁰ Christine S. Moyer, *Doctor Discipline by States Medical Boards*, AM. MED. NEWS, Apr. 19, 2010.

⁵¹¹ See, e.g., *Abofreka v. VA Bd. Of Med.*, No. 2793-06-4, 2007 WL 2301727, at *1, *9 (Va. Ct. App. 2007) (affirming suspended medical license for failure to obtain patient’s informed consent for anesthesia); *In re Kaphan*, No. BPMC 98-142, 1998 WL 35078544 (N.Y. Bd. Prof’l. Med. Conduct June 30, 1998) (suspending medical license after finding physician performed a procedure on Patient B without consent); *In re Burman*, No. BPMC 00-221, 2000 WL 35364277 (N.Y. Bd. Prof’l. Med. Conduct July 30, 2000) (finding physician failed to obtain Patient A’s informed consent to apply clamps to fallopian tubes); ROBERT D. MILLER, PROBLEMS IN HEALTH CARE LAW 412-14 (9th ed. 2006) (collecting cases). It is difficult to find these cases. State medical boards organize their publicly available information only by clinician name and license number, so that patients can “check out” their doctor. Cf. Thaddeus M. Pope, *Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases*, 9 MARQ. ELDER’S ADVISOR 229, 231 n.8 (2008) (bemoaning the lack of a “systematic way to locate unreported cases”).

⁵¹² See discussion *infra* Section V.E., “Other Liability Costs.”

Medical Board.⁵¹³ But during the pendency of proceedings, Dr. Dworkin's hospital cancelled all his admitting and treating privileges.⁵¹⁴ Dr. Dworkin was dropped from almost all his patients' insurance programs.⁵¹⁵ And his malpractice carrier cancelled his insurance policy and refused to provide legal assistance or cover legal costs.⁵¹⁶ In the end, Dr. Dworkin lost his office and his office staff, and he was shunned by colleagues and former acquaintances.⁵¹⁷ And he was inundated with requests from patients to transfer records.⁵¹⁸

2. Health Care Facility Inspections

Just as individual clinicians have duties to honor patient treatment refusals, most health care facilities also have statutory and regulatory duties to honor advance directives and refusal of treatment. Failure to comply with these duties can lead to fines and other sanctions.

For example, New Jersey provides: "A health care institution that intentionally fails to act in accordance with the requirements of this act shall be subject to a fine of not more than \$1,000 for each offense."⁵¹⁹ Similarly, under New Jersey's new POLST law, "A health care institution that intentionally fails to act in accordance with the requirements of this act shall be liable to a civil penalty of not more than \$1,000 for each offense."⁵²⁰

Furthermore, while state governments oversee the licensing of nursing homes, the federal government also has a significant role, because substantial Medicare and Medicaid dollars are used to cover nursing home care and services for the elderly and

⁵¹³ Steven Ertelt, *Delaware Abortion Doc Wins Hearing, Reg Bill Moves Ahead*, LIFENEWS.COM (Apr. 13, 2011, 5:41 PM), <http://www.lifenews.com/2011/04/13/delaware-abortion-doc-wins-hearing-reg-bill-moves-ahead/>. Dworkin was not charged with administering unwanted treatment; however, he was charged with assisting a Pennsylvania doctor with running a filthy, dangerous abortion center. *Id.* The center was responsible for deaths and injuries to women resulting from botched abortions. *Id.*

⁵¹⁴ Albert Dworkin, *You Could Be Next*, 83 DEL. MED. J. 273, 274 (2011), available at <http://www.medsocdel.org/Portals/1/DMJ/9-2011September.pdf>.

⁵¹⁵ *Id.* The insurance companies that dropped Dr. Dworkin included BCBS, Medicare, Medicaid, Aetna, Delaware Physicians Care, Multiplan, UnitedHealthcare, and Devon. *Id.*

⁵¹⁶ *Id.*

⁵¹⁷ *Id.*

⁵¹⁸ *Id.*

⁵¹⁹ N.J. STAT. ANN. § 26:2H-78(b) (West 2007).

⁵²⁰ N.J. STAT. ANN. § 26:2H-139(b) (West Supp. 2012).

disabled.⁵²¹ The Centers for Medicare & Medicaid Services (“CMS”) contract with states to monitor those nursing homes that want to be eligible to provide care to Medicare and Medicaid beneficiaries.⁵²² So the state, usually through its health department or department of human services, has the responsibility for certifying a facility’s compliance or noncompliance with quality and performance standards in Medicare and Medicaid regulations.⁵²³

These types of obligations have been aggressively enforced.⁵²⁴ For example, the Kentucky Cabinet for Health and Family Services Office of Inspector General (“OIG”) is Kentucky’s regulatory agency for licensing all long-term care facilities.⁵²⁵ To monitor and enforce the rights of residents in Kentucky long-term care facilities, the OIG conducts unannounced inspections.⁵²⁶ One of the rights that the OIG enforces is the right to refuse medical treatment.⁵²⁷ In March 2008, the OIG issued a citation to Green Meadows Health Care for trying to revive a resident who had signed a DNR order.⁵²⁸ And in March 2009, it cited Louisville’s Jefferson Manor after staff resuscitated 95-year-old Eva Karem despite a DNR order.⁵²⁹

⁵²¹ *Nursing Homes*, MEDICARE.GOV, <http://www.medicare.gov/nursing/aboutinspections.asp> (last visited Apr. 30, 2013). A similar tool for hospitals is now available from the Association of Health Care Journalists, HOSPITALINSPECTIONS.ORG, <http://www.hospitalinspections.org> (last visited May 4, 2013).

⁵²² *Id.*

⁵²³ Philip C. Aka et al., *Political Factors and Enforcement of the Nursing Home Regulatory Regime*, 24 J.L. & HEALTH 1, 16-17 (2011). Federal regulations outline both the substantive standards as well as the structure of the inspection process. *Id.* After the inspection team leaves the facility, it finalizes the statement of deficiencies and submits a copy to the facility and to Centers for Medicare & Medicaid. *Id.* at 17-18. The facility must then submit a “plan of correction” indicating how and when it will correct the deficiencies. *Id.* at 13. Failure to implement the plan of correction results in sanctions on the facility. *Id.*

⁵²⁴ Charles Ornstein & Lena Groeger, *Nursing Home Inspect*, PROPUBLICA (Apr. 1, 2013), <http://projects.propublica.org/nursing-homes> (providing online database of recent nursing home inspections and deficiencies).

⁵²⁵ KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES, *Health Care and Long Term Care Applications*, KENTUCKY.GOV (Jan. 10, 2011), <http://chfs.ky.gov/os/oig/lcapppls.htm>.

⁵²⁶ KY. REV. STAT. ANN. § 216.530 (West 2007).

⁵²⁷ 42 C.F.R. § 483.10(b)(4) (2007) (stating “[t]he resident has the right to refuse treatment”).

⁵²⁸ Ray Mullman, *Nursing Homes Ignorant of DNR Purpose and Policy*, S.C. NURSING HOME BLOG (May 25, 2009), <http://www.scnursinghomelaw.com/2009/05/articles/regulatory-enforcement/nursing-homes-ignorant-of-dnr-purpose-and-policy/>.

⁵²⁹ *Resuscitation Orders Not Always Followed in Ky*, THE INDEPENDENT ONLINE (Mar. 22, 2009), <http://dailyindependent.com/local/x1192779354/Resuscitation-orders-not-always-followed-in-Ky>.

Other states have similarly sanctioned facilities for resuscitating residents contrary to their instructions.⁵³⁰ For example, in June 2012, a Florida facility was cited for initiating CPR on a resident “who had stated on admission that he did not want to be resuscitated.”⁵³¹

Furthermore, the states have been sanctioning facilities not only for inappropriate resuscitation, but also for improperly or inadequately recording resident preferences not to be resuscitated.⁵³² For example, one facility “failed to place the

⁵³⁰ See, e.g., MEDICARE, SURVEY REPORT OF WOODLAND VIEW CARE AND REHABILITATION NO. 375364 (June 22, 2010), available at <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=375364&SURVEYDATE=June%2022,%202010>; MEDICARE, SURVEY REPORT OF LAWDALE HEALTHCARE & WELLNESS CENTRE LLC NO. 555816 (June 11, 2012), available at <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=555816&SURVEYDATE=June%2011,%202012>; MEDICARE, SURVEY REPORT OF CONSULATE HEALTH CARE OF WINTER HAVEN NO. 105998 (June 8, 2012), available at <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=105998&SURVEYDATE=June%20%208,%202012>; MEDICARE, SURVEY REPORT OF SANS SOUCI REHABILITATION AND NURSING CENTER NO. 335398 (Aug. 23, 2012), available at <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=335398&SURVEYDATE=08/23/2012>; MEDICARE, SURVEY REPORT OF ST. BARNABAS REHABILITATION & CONTINUING CARE CTR. NO. 335775 (Sept. 11, 2012), available at <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=335775&SURVEYDATE=September%2011,%202012>; MEDICARE, SURVEY REPORT OF GRAMERCY COURT NO. 555459 (Nov. 2, 2012), available at <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=555459&SURVEYDATE=November%20%202,%202012>.

⁵³¹ DEPT OF HEALTH & HUMAN SERVS CTRS FOR MEDICARE & MEDICAID SERVS, SURVEY OF CONSULATE HEALTH CARE OF WOODHAVEN No. 105998 (2012), available at <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=105998&SURVEYDATE=June%20%208,%202012&AspxAutoDetectCookieSupport=1>.

⁵³² See, e.g., Brookridge Life Care and Rehab. v. CMS, No. CR1538 (Dec. 8, 2006), available at <http://www.hhs.gov/dab/decisions/CR1538.htm> (finding facility failed to ensure “that the code status was documented in the clinical record”); Omni Manor Nursing Home v. Thompson, 151 Fed. Appx. 427, 429 (6th Cir. 2005) (finding the facility failed to ensure Resident 27’s DNR status); DEPT OF HEALTH & HUMAN SERVS CTRS FOR MEDICARE & MEDICAID SERVS, SURVEY OF CONSULATE HEALTH CARE OF OAKGROVE SPRINGS CARE CENTER NO. 056350 (Sept. 27, 2012), available at <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=056350&SURVEYDATE=September%2027,%202012>; MEDICARE, SURVEY REPORT OF WALDORF CENTER NO. 215273 (Oct. 24, 2012), available at <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=215273&SURVEYDATE=October%2024,%202012>; MEDICARE, SURVEY REPORT OF RETAMA MANOR NURSING CENTER/PLEASANTON SOUTH NO. 675428 (July 5, 2012), available at <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=675428&SURVEYDATE=July%20%205,%202012>; MEDICARE, SURVEY REPORT OF USSERY ROAN TEXAS STATE VETERANS HOME NO. 676157 (Oct. 11, 2012), available at <http://www.medicare.gov/>

signed DNRs in the patient's records" placing them "at risk for their [DNR] wishes not being followed."⁵³³ Another facility lacked "necessary policies and procedures for assuring that residents' advance directives would be honored."⁵³⁴

3. Medicare Conditions of Participation

Not only have the states been aggressively enforcing patient rights protections, but those regulations have themselves recently been strengthened.⁵³⁵ For example, federal regulations have long provided that a nursing home resident "has the right to refuse treatment"⁵³⁶ But in late 2012, CMS strengthened the implementation of this standard by better clarifying that "the resident may not be treated against his/her wishes."⁵³⁷ Specifically, CMS issued detailed guidance for surveyors, helping them identify noncompliant practices, policies, and procedures.⁵³⁸

These surveyors conduct observations, interviews, and record reviews to assess compliance at two levels.⁵³⁹ First, they determine whether "orders are consistent with

nursinghomecompare/SurveyReportDetail.aspx?ID=676157&SURVEYDATE=October%2011,%202012.

⁵³³ DEPT OF HEALTH & HUMAN SERVS CTRS FOR MEDICARE & MEDICAID SERVS, SURVEY OF CONSULATE HEALTH CARE OF WOODHAVEN NO. 105998 (2012), *available at* <http://www.medicare.gov/nursinghomecompare/SurveyReportDetail.aspx?ID=105998&SURVEYDATE=June%20%2008,%202012&AspxAutoDetectCookieSupport=1>.

⁵³⁴ *Evergreen Commons v. CMS*, No. CR2372 (May 20, 2011), *available at* www.hhs.gov/dab/decisions/civildecisions/cr2372.pdf.

⁵³⁵ Because federal law in this area seeks to enforce residents' rights under state law, the strengthening of state law strengthens federal law. *See* Pope & Hexum, *supra* note 47 (discussing POLST); *see also* CMS, *EHR Incentive Programs*, CMS.GOV (Aug. 27, 2012, 12:20 PM), <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms> (providing incentive payments by including the charting of advance directives as one "meaningful use" outcome).

⁵³⁶ 42 C.F.R. § 483.10(b)(4) (2012).

⁵³⁷ CTRS FOR MEDICARE & MEDICAID SERVS, CENTER FOR CLINICAL STANDARDS AND QUALITY/ SURVEY & CERTIFICATION GROUP 8 (2012), *available at* <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-12-47.pdf>; *see also* Janet K. Feldkamp, *Four Recent Releases by CMS for Nursing Facilities*, AMERICAN HEALTH LAW ASS'N, Dec. 2012, at 1, *available at* http://m.babc.com/files/Publication/d17cf251-c6ae-49ba-88b4-391f51ad6246/Presentation/PublicationAttachment/27ac985a-877d-43c7-bf47-ad2950933457/LTC_Dec12.pdf.

⁵³⁸ *See generally*, CTRS FOR MEDICARE & MEDICAID SERVICES, *supra* note 537.

⁵³⁹ *Id.* at 10-13.

the resident's documented choices and goals."⁵⁴⁰ Second, they determine whether "any treatment or interventions have been ordered . . . that are inconsistent with the resident's documented acceptance or refusal of treatment or with an existing advance directive."⁵⁴¹ In short, new CMS guidance directs surveyors to ensure (1) that orders match wishes and (2) that treatment matches orders.

Furthermore, the new guidance not only strengthens the rigor of the inspection process relative to life-sustaining treatment, but it also increases the penalties for noncompliance. The new guidance provides that "failure to obtain and implement medical orders related to life-sustaining treatments" is the highest level deficiency: "Level 4: Immediate Jeopardy to Resident Health or Safety."⁵⁴²

D. Criminal Sanctions

Most states impose criminal sanctions to protect the integrity of advance directives. But criminal prohibitions typically do not directly address compliance by health care providers. Instead, these statutes prohibit the nonconsensual concealment, defacement, modification, and falsification of an advance directive.⁵⁴³ They also prohibit coercing or fraudulently inducing the execution of an advance directive.⁵⁴⁴

But there has been growing recognition that clinician noncompliance itself sometimes warrants criminal sanctions. For example, the Montana Supreme Court recently observed that that state's "legislature criminalized the failure to follow a patient's end-of-life instructions."⁵⁴⁵ A Montana physician "who willfully fails to record the determination of terminal condition or the terms of a declaration" is punishable by a maximum \$500 fine, a maximum one year in jail, or both.⁵⁴⁶

This is consistent with a broader trend toward greater use of the criminal law to address clinician noncompliance with governing rules and standards.⁵⁴⁷ This is especially

⁵⁴⁰ *Id.* at 12.

⁵⁴¹ *Id.* at 13.

⁵⁴² *Id.* at 20.

⁵⁴³ See, e.g., ARK. CODE ANN. § 20 -17-209 (2005); MONT. CODE ANN. § 50 -9-105 (2011); N.J. STAT. ANN. § 26-2H-78(c) (2007).

⁵⁴⁴ *Id.*

⁵⁴⁵ *Baxter v. State*, 224 P.3d 1211, 1219 (Mont. 2009).

⁵⁴⁶ MONT. CODE ANN. § 50-9-206(2) (2011).

⁵⁴⁷ See generally ROBERT D. MILLER, PROBLEMS IN HEALTH CARE LAW 690-91 (9th ed. 2006); James A. Filkins, *With No Evil Intent: The Criminal Prosecution of Physicians for Medical Negligence*, 22 J. LEGAL MED. 467 (2001); Diane E. Hoffmann, *Physicians Who Break the Law*, 53 ST. LOUIS U. L.J.

true with respect to Medicare fraud and abuse.⁵⁴⁸ For example, billing for unwanted treatment can constitute not only a civil, but also a criminal false claim, because it is medically unnecessary.⁵⁴⁹

E. Other Liability Costs

Just as clinicians may suffer financial penalties related to, though distinct from, civil liability, clinicians may also suffer financial penalties separate and independent from administrative sanctions. Most notably, the process of responding to a regulatory investigation can easily reach \$10,000.⁵⁵⁰ Plus, there are other costs of emotional distress, lost time, and reputation.⁵⁵¹

VI. Conclusion

The right to refuse life-sustaining treatment has been established for decades. But as with many principles in bioethics, there remains a wide chasm between legal and ethical principles, on the one hand, and the reality of clinical practice, on the other hand. Significant numbers of patients receive treatment inconsistent with their wishes and instructions.⁵⁵² And this materially contributes to the nearly \$700 billion wasted in U.S. health care annually.⁵⁵³

1049 (2009); Esther B. Fein, *In Rare Case, Doctor Faces Jail Time for Negligence*, N.Y. TIMES, May 17, 1997.

⁵⁴⁸ See *supra* Section V.A.10.

⁵⁴⁹ See, e.g., *U.S. v. Campbell*, 845 F.2d 1374 (6th Cir. 1988).

⁵⁵⁰ Seth A. Seabury et al., *On Average, Physicians Spend Nearly 11 Percent Of Their 40-Year Careers With An Open, Unresolved Malpractice Claim*, 32 HEALTH AFFAIRS 111 (2013); Sandra H. Johnson, *Childress Lecture: Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973, 1001 (2009) (explaining physicians' fear of investigative process and associated financial costs); Pauline W. Chen, *The Drawn Out Process of the Medical Lawsuit*, N.Y. TIMES, Jan. 24, 2012 ("I lost year of my life . . . That lawsuit completely consumed me.") (quoting a physician); Birdstrike, *Why a Malpractice Win for Doctors Feels Like a Great Loss*, KEVINMD (Mar. 22, 2013), <http://www.kevinmd.com/blog/2013/03/malpractice-win-doctors-feels-great-loss.html>.

⁵⁵¹ Johnson, *supra* note 550, at 1002 (discussing penalties embedded in the investigative process); see generally *Tyler v. Dworkin*, 747 A.2d 111 (Del. Super. Ct. 1999) (finding defendant helped run abortion business).

⁵⁵² See generally H. GILBERT WELCH, *OVERDIAGNOSED: MAKING PEOPLE SICK IN THE PURSUIT OF HEALTH* (2012); SHANNON BROWNLEE, *OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER AND POORER* (2007); Donald M. Berwick & A.D. Hackbarth, *Eliminating Waste in US Health Care*, 307 JAMA 1513 (2012); E.S. Fisher & H.G. Welch, *Avoiding the Unintended Consequences of Growth in Medical Care*, 281 JAMA 446 (1999).

⁵⁵³ Nicole Cafarella Lallemand, *Reducing Waste in Health Care*, HEALTH AFFAIRS HEALTH POLICY BRIEF (Dec. 13, 2012), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=82.

Commentators are correct that “unless health care providers . . . face consequences for ignoring or failing to follow a patient’s directives, the public policy favoring these directives stands to be undermined.”⁵⁵⁴ After all, providers are rational. Only when “injuring patients becomes more expensive than not injuring them, [will] providers will stop injuring patients.”⁵⁵⁵

Clinicians’ behavior is guided: (1) by what they think the law is; (2) by what they think the chances of enforcement are; and (3) by what they think the sanctions are. Less influential is: (a) what the law actually is; (b) what the chances of enforcement actually are; and (c) what the sanctions actually are. In contrast to other commentators, I have aimed to establish that the prospect for enforcement and consequences is not nearly as dismal as often depicted. Sanctions are more severe and more frequent than is commonly thought. This is an important starting point for changing clinician perceptions, and, consequently, clinician behavior.

“Overtreatment also includes intensive care at the end of a person’s life when alternative care would have been preferred by the patient and family” *Id.* The Institute of Medicine estimates that \$210 billion of \$765 billion in waste is due to “unnecessary services.” Institute of Medicine of the National Academies, *The Cost of Healthcare- How Much is Waste?*, THE HEALTHCARE IMPERATIVE (Dec. 5, 2011, 9:08 AM), available at <http://www.iom.edu/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx>; INST. OF MED. OF THE NAT’L ACAD., BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTHCARE IN AMERICA 3-12 (2012).

⁵⁵⁴ Anderson v. St. Francis–St. George Hosp., No. C-930819, 1995 WL 109128, at *4 (Ohio Ct. App. March 15, 1995).

⁵⁵⁵ Hyman & Silver, *supra* note 383, at 1131.